STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155359	B. WING		10/24/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				INCHESTER RD	
RIVERBE	END HEALTH CAR	E CENTER		VAYNE, IN46819	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or a Recertification and	F0000	Please accept this Plan of	
	State Licensure	Survey.		Correction as our credible	
				allegations of compliance. T Plan of Correction does not	ne
	Survey dates: C	October 17, 18, 19, 20, 21,		constitute or aggreement by	the
	& 24, 2011			provider of the truth of facts	
				conclusions set forth in this	
	Facility number	000250		statement of deficiences. The	
	Provider numbe			Plan of corrections is prepar	
	AIM number: 1			soley because it is reguired Federal and State Law.	ру
	Allyl humber.	00287780		Riverbend Health Care alleg	ation
				of compliance date is 11/23/	
	Survey team:			0. 00pa00 date 10 1 1.20.	
	Sue Brooker RD	OTC			
	Rick Blain RN				
	Sheryl Roth RN				
	Angie Strass RN	1			
	Census bed type				
	SNF/NF: 46				
	Total: 46				
	10141. 70				
	Comana				
	Census payor ty	pe.			
	Medicare: 4				
	Medicaid: 38				
	Other: 4				
	Total: 46				
	Stage 2 sample:	36			
	These deficienci	ies also reflect state			
		accordance with 410 IAC			
	16.2.	accordance with 410 IAC			
	10.4.				
	•				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UZK811

Facility ID:

000250

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	i:	(X2) MULTIPLI A. BUILDING	E CONSTR 00 —			(X3) DATE COMPL	ETED		
		155359		B. WING				10/24/2	UII		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819							
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCI CY MUST BE PERCEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	CF	(EACH CORRECTIVE	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIAT IENCY)	Έ	(X5) COMPLETION DATE		
		LSC IDENTIFYING INFORM pleted 10/30/11			CF	ROSS-REFERNCEI DEFIC	ACTION SHOULD BE D TO THE APPROPRIAT IENCY)				
FORM CMS-2	567(02-99) Previous Version	ons Obsolete E	vent ID: UZ	K811 Faci	ility ID:	000250	If continuation sh	leet Pa	ge 2 of 91		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155359	B. WIN			10/24/2	011
			P. (11)		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0272 SS=D	periodically a com standardized repro each resident's ful A facility must mal	ke a comprehensive					
	assessment of a right real real real real real real real real	esident's needs, using the he State. The assessment ast the following: demographic information; e;; or patterns; being; ng and structural problems; e and health conditions; onal status;					
	Based on obse and interview, to accurately assessment. To provide accurate	trvation, record review the facility failed to less 2 of 3 residents and #51) who met the land /Dental Status and lethe information on	FC	272	F272 SS: D Comprehensive assessmentsIt is the policy of Riverbend Health Care Centrocomply with regulatory requirement comprehensive assessments.1. a. Res #53 re-assessed for dental and of care related to ill-fitting denture Care plan revised to reflect of status and interventions. b. #37 has been re-assessed by MDS to include hearing deficitions.	er to ral ires. iral Res y	11/23/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UZK811 Facility ID:

000250

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	A. BUII	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 10/24/2	ETED
	100000	B. WIN		I DEDUCA COMPLETE CONTROL CONTROL	10/24/2	011
NAME OF PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
RIVERBEND HEALTH CAR	E CENTER			VAYNE, IN46819		
` '	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	dents (Resident #37)			and care plan will be revised include residents preference		
	ssessments on the			to wear adaptive hearing aid		
MDS.				and interventions will include		
				anticipate adjusting speaking	g tone	
Findings include	de:			during communication. c.	_	
				Resident #51 re-assessed b MDS to include accurate ora		
	53's record was			assessment.2. Facility MDS		
	0/19/11 at 10:10 a.m.			coordinator will conduct a re		
	icated Resident #53's			of residents most current or		
	uded, but were not			recent MDS assessment and compare to residents actual	-	
	blood pressure,			and hearing assessment to	Ulai	
	r disorder, bilateral			assure care plan reflects		
	enal failure and current			residents current oral and he	earing	
history of smol	King.			status.3. DON or designee		
The same plan	for only one definit			re-educate MDS coordinator RAI guidelines related to acc	•	
•	for self care deficit,			assessments oral and	diate	
), with a goal date of			hearing.DON or designee wi	II QA	
· ·	ated "assist with oral			all new admissions		
	lly. The care plan did e resident had an upper			comprehensive MDS assessments sections include	۵	
	• •			oral/dental and hearing x 3	C	
	wer partial. Nor did the ne resident preferred			months and compare to resi	dents	
	denture/partial.			actual status and assure car	е	
That to wear his	uchture/partial.			plan reflects accurate assessments.4. Results from	m O A	
The annual Mi	DS, dated 9/19/11,			reviews will be forwarded to	-	
	dent #53 did not have			Facility Risk Management Q		
	loosely fitting full or			Improvement (RMQI) commi		
	[chipped, cracked,			for further review and	10 /	
'	ose]. The MDS also			reccommendations ,until 100 compliance is achieved time		
	ovious or likely cavity or			months.		
	teeth or difficulty with					
chewing.	tooth of dimodity with					
onewing.						
The October 2	011 Medication Record					
for Resident #5						

000250

	OF CORRECTION	X1) PROVIDER/SUPPL		(X2) M	ULTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	MBER:	A. BUI	LDING	00		COMPL	
		155359		B. WIN				10/24/2	017
NAME OF I	PROVIDER OR SUPPLIER					ADDRESS, CITY, ST			
DI) (ED.	-ND HEALTH 0:	E OFNITES				INCHESTER RI			
	END HEALTH CARI				FORTV	VAYNE, IN4681	19		
(X4) ID		TATEMENT OF DEFICE			ID		PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCED!			PREFIX	CROSS-REFERENC	VE ACTION SHOULD BE CED TO THE APPROPRIAT FICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INF		+	TAG	DEF	/		DATE
		oft diet d/t [due t	υj						
	chewing difficu	ıty.							
	Dental visite for	r adjustments to	`						
		clinical record							
		, 8/9/11, 6/15/1							
		5/4/11 and 2/1/	-						
		extractions]. A							
		extractionsj. A)/12/11 indicated							
	didn't feel Resi		u II C						
	motivated to su								
	dentures.	icceeu willi iiis							
	uentures.								
	Resident #53 w	vas observed si	tting up						
	in a wheelchair		ung up						
			ident						
		5 p.m. The res							
		to have missing							
		ining teeth which							
	1 •	with plaque buil e' between the lo	•						
	front teeth.	: Detween the K	JWEI						
	i iioni leelii.								
	The MDS pure	e was interview	ed on						
		0 p.m. During t							
	she was unable	MDS nurse indic	aicu						
		of an oral asse	comont						
		ed for the 9/19/1							
		n 10/24/11, the							
		I she notified nu	•						
		on what assessi							
		inical review sh							
		n completed by	-						
		ave included an							
	inspection of th	e resident's lips	s, teetn,						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete	Event ID:	UZK811	Facility 1	ID: 000250	If continuation sh	eet Pa	ge 5 of 91

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 10/24/20	ETED	
NAME OF F	PROVIDER OR SUPPLIER		_		DDRESS, CITY, STATE, ZIP CODE		
RIVERBE	END HEALTH CARI	E CENTER			INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	· · · · · · · · · · · · · · · · · · ·	ous membranes, facial pain, etc.					
	10/24/11 at 1:2 indicated he had a lower partial correctly so he	vas interviewed on 5 p.m. The resident ad upper dentures and which did not fit chose not to wear er indicated he keeps er in his room.					
	The record indi diagnoses inclu limited to, cong	0/17/11 at 2:30 p.m. cated Resident #37's uded, but were not estive heart failure, disease, depression,					
	indicated Resid to severe heari evaluation furth	ner indicated Resident earing aids but they					
	Resident #37 li	·					
	The care plan f	or Alteration in n, dated 7/6/09 with a					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	ľ ′	E SURVEY LETED 2011
	PROVIDER OR SUPPLIEF		7519 V	ADDRESS, CITY, STATE, ZIP C VINCHESTER RD WAYNE, IN46819	CODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Resident #37 h	/29/11, indicated nad an alteration in due to hearing				
	10/17/11 at 12: interview, the r understand spo	vas interviewed on 18 p.m. During the esident was unable to oken speech unless the ose to the resident and me of speech.				
	#4 on 10/21/11 the interview, 0	as conducted with CNA at 1:40 p.m. During CNA #4 indicated was hard of hearing and earing aids.				
	reviewed on 10 Diagnoses inclimited to, wear (hypertension), hypertrophy),	or Resident #51 was 0/20/11 at 12:30 PM. ude, but were not okness/confusion, HTN BPH (benign prostatic Bipolar disorder, entia, chronic kidney re anxiety, and				
	on 10/17/2011	view with Resident #51 at 3:15 P.M., the s own natural teeth,				

STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMP	LETED
		155359	B. WIN			10/24/2	2011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		7519 W	INCHESTER RD		
RIVERB	END HEALTH CAR				VAYNE, IN46819		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION CONTROL OF A CORRECTION OF CORRECTION OF CORRECTION CONTROL OF THE PROVIDENCE OF T		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
TAG			+	IAU			DATE
	missing.	pper teeth broken or					
	dated 5/27/11,	data collection form, indicated Resident #51 I teeth, and some were chipped.					
	· ·	MDS, dated icated Resident #51 teeth and no tooth					
	8/09/2011, ind	nange MDS, dated, icated Resident #51 teeth and no tooth					
	Assessment In provided by the 10/21/11 at 2:0 "checkno nat fragment(s) (er resident is ede natural teeth of RAI further ind or likely cavity	ion of the Resident strument (RAI), e facility MDS nurse on 00 P.M., indicated tural teeth or tooth dentulous): if the intulous or lacks all r parts of teeth." The icated "checkobvious or broken natural teeth: broken tooth is seen."					
	am. During the nurse indicated	OS nurse was 10/21/2011 at 11:00 e interview, the MDS d the MDS dated the MDS dated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		MULTIPLE CO JILDING ING	NSTRUCTION 00) DATE SURVEY COMPLETED 0/24/2011			
	PROVIDER OR SUPPLIER		<u>, </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION b both coded		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE!	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE			
		Resident #51's dental d have his own teeth en teeth.								
	3.1-31(d)									
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	UZK81	1 Facility I	D: 000250	If continuation sheet	Page 9 of 91			

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	COMPLETED	
		155359	B. WIN			10/24/20	011	
			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			7519 W	INCHESTER RD			
RIVERBE	END HEALTH CARE	E CENTER		FORT V	VAYNE, IN46819			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE	
F0279 SS=D	A facility must use assessment to dev	velop, review and revise the						
00 B		hensive plan of care.						
	_	evelop a comprehensive						
		resident that includes						
	I	tives and timetables to meet al, nursing, and mental and						
		ds that are identified in the						
	comprehensive as							
	The care plan mus	st describe the services that						
		d to attain or maintain the						
		practicable physical, losocial well-being as						
		83.25; and any services that						
		e required under §483.25						
		ed due to the resident's						
		under §483.10, including the attention in the litment under §483.10(b)(4).						
	_	rvation, record review	FO	279	F 279 SS: D Develop		11/23/2011	
		the facility failed to	10	219	Comprehensive care plansIt	is	11/23/2011	
		care plan with the			the policy of Riverbend Heal	th		
	l .	of the dycem (non-slip			Care Center to comply with			
		wheelchair for 1 of 5			regulatory requirement development of compressive	care		
	·	dent #37) who met the			plans.1. Res #37's Care Pla			
	· ·	dents in the Stage 2			revised to include the interve	ntion		
	Sample of 26.	aonto in the Stage 2			of dycum (non-slip material).	2.		
	25				The facility has conducted a review of residents who have	_		
	Findings includ	e:			fallen two or more times in the			
	_				past 6 months from w/c to in			
	On 10/20/11 at	3:02 p.m., Resident			care planned interventions a			
	#37 was observ	ved in her room, no			place and effective.3. Licens staff will be re-educated on f			
	dycem was not	ed in the wheelchair.			policy and procedure related			
					fall risk and implementation			
		9:10 a.m., Resident			care-planned interventions a place and effective. The facili			
		ved in bed. The			interdisciplinary team (IDT) v	-		
	resident's whee	elchair was sitting			review residents who have fa			

000250

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155359		LDING	00	10/24/2	
		100000	B. WIN		DDDEGG CITY CTATE 7ID CODE	10/2 1/2	011
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		with a pressure			in daily clinical meeting to en appropriate/effective interver		
	_	on in the seat along			are implemented and care pl		
		sling pad. No dycem			revised to reflect new		
	was observed.				interventions. Residents who		
	A rovious of the	aliniaal record for			have fallen referred to therap post fall. DON or designee w	•	
		clinical record for			conduct random visual		
	· · · · · · · · · · · · · · · · · · ·	on 10/17/11 at 2:30 a telephone order,			observation of 2 residents da	•	
	•	for dycem to be placed			two weeks then weekly x 1 m	nonth	
	-	37's wheelchair seat.			then monthly to assure interventions for fall risk are i	n	
	On Resident #3	or s wheelchair seat.			place as care planned.4. Re		
	Δ condition cha	ange form, dated			from QA reviews will be		
		ted Resident #37 had			forwarded to the Facility Risk	(
	1	from her wheelchair in			Management Quality Improvement (RMQI) commi	ttoo	
		n. The form indicated			for further review and	uee	
	Resident #37 s				reccommendations as indica	ted.	
		t and was assisted to					
	the floor by sta						
	-	dated 1/15/11 at 11:30					
	· ·	Resident #37 was					
		floor after the resident					
		heelchair. The note					
		d the resident's hoyer					
	•	ved and dycem was					
	placed in the cl	naır.					
	A facility care r	olan Potential for Falls,					
		with a goal date of					
	11/29/11, did n						
	intervention of						
	wheelchair.	,					
	CNA #4 was in	terviewed on 10/24/11					
	at 9:10 a.m. D	uring the interview,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/24/2011
	ROVIDER OR SUPPLIER		STREET A 7519 W	ADDRESS, CITY, STATE, ZIP CODE INCHESTER RD	1
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	VAYNE, IN46819 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ed Resident #37 used	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	not anymore.	non-slip material) but She further indicated e wheelchair currently,			
	The current pol Reduction & Ma 8/10, was provi Nursing on 10/2 The policy lister interdisciplinary resident/patient family/responsi and implement interventions to or injuries while and independe plan to indicate interventions as and document and second s	ble party to identify appropriate reduce the risk of falls maximizing dignity nceRevise the care changes in sindicatedModify goals and interventions communicate changes			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359				LDING G	NSTRUCTION 00	(X3) DATE ; COMPL 10/24/2	ETED
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RIVERBE	END HEALTH CARE	CENTER			VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0282 SS=G	The services proving acility must be proving accordance with plan of care. Based on obse record review the follow a physicing medication for experiencing in requesting pain. This residents (Residents (Resident #37) for accidents in 26.	ded or arranged by the ovided by qualified persons a each resident's written rvation, interview and the facility failed to an's order for pain 1 of 3 residents who met the criteria esulted in Resident #65 tense pain and a medication frequently. In failed to toilet as care plan 1 of 5 dent #23) who met the ting. The facility follow a physician's displint for 1 of 3 dent #5) who met the tioning and the facility physician's orders for the material in the 1 of 5 residents who met the criteria the Stage 2 Sample of	F0	282	F 282 SS: G Services by Qualified Persons/Per Care I is the policy of Riverbend He Care Center to comply with regulatory requirement service provided by qualified persons plan of care.Res#65 Facility unable to apply specific correaction due to resident discharge.Res #23 re-assess for bladder toileting plan and plan as indicated.Res #5 is currently on therapy caseloar evaluation and treatment for application per MD order.Res #37's Care Plan revised to include the intervention of dy (non-slip material).1. Facility re-assessed current resident pain and current physicians orders for pain medication to ensure facility is meeting residents comfort needs.2. Facility has conducted a reviresients who are incontinent bladder and on toileting prog to ensure care plan is accurated appropriately.Facility has conducted a review of reside with adaptive equipment(spliper physicians order to ensure present and appropriately applied. Facility has conducted review of residents who have fallen two or more times in the	alth ces s per is ective sed care d for splint s cum has 's ew of of rams te nts nts) re ted a	11/23/2011

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	
		155359	B. WIN			10/24/20	011
NAME OF I	DROVIDED OD GLIDDI IEE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			7519 W	INCHESTER RD		
	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	a.m., indicated	<u> </u>			past 6 months from w/c to er care planned interventions a		
	_	uded, but were not			place and effective.3. Licens		
		noma of left tongue			staff re-educated on facility p		
	with left cervica				and procedures related to: F	all	
		achexia (weight loss			risk and intervention		
		sting), COPD (chronic			management, bladder toilet		
	i i	monary disease), HTN			programming, adaptive equipment, physician orders	and	
	(hypertension),	and osteoarthritis.			pain management.Facility (IE		
					will review new physician ord		
	A physician ord	der from the Oncologist			therapy recommendations,		
	for Resident #6	65, dated 10/4/11,			residents with new onset pair		
	indicated Lorta	b Elixir 7.5/500 mg 15			significant changes in conditi		
	ml per G-tube	every 4 hours PRN (as			new assitive/splints application the daily clinical meeting and		
	needed) for pa	in.			update care plan as	·	
					indicated.Pain assessments	will	
	A facility physic	cian order for Resident			be completed every shift and		
	1	7/11, indicated a			documentation on the reside		
	Fentanyl patch	-			medication administration red to ensure residents needs	cord	
		er hour) once every			met.The facility interdisciplina	arv	
		pain. PRN (as needed)			team (IDT) will review reside		
	pain medication	,			who have fallen in daily clinic		
	· ·	n 325-650 every 4			meeting to ensure		
		RN, Acetaminophen			appropriate/effective interver		
	1	ams) per feeding tube			are implemented and care pl revised to reflect new	an	
	1 0 1	caine HCl 2% orally			interventions. Residents who	o	
		every 4 hours PRN.			have fallen referred to therap		
		order did not indicate			post fall. DON or designee w	rill	
		as receiving the Lortab			QA new admission pain		
		•			assessments and physician		
	Elixii as didere	d by the Oncologist.			orders for pain medication to ensure availability of pain		
	Am Admaianian	Madiaal I liator : -f			medication and effectiveness	s of	
		Medical History of			pain medication x 3 months t		
		ination written by the			assure accurate		
		in for Resident #65,			assessment.DON or designe		
		history of any drug			QA residents on toileting pro	-	
	use"				daily x 2 weeks then weekly	x 4	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILE	DING	00	COMPI		
		155359		B. WING			10/24/2	:011	
NAME OF F	PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE			
				7519 WINCHESTER RD					
RIVERBE	END HEALTH CARI	E CENTER		[FORT W	VAYNE, IN46819			
(X4) ID		TATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FU		P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATI	ON)		TAG	DEFICIENCY)		DATE	
			,			then monthly to ensure residential to			
	, , ,	cian order for Residen				thr residents plan of care.DC	•		
		12/11, indicated to sta				designee will conduct rando			
		mg orally every 4 hour				visual observation of 2 resid	ents		
		when current supply of				daily x two weeks then week			
	Vicodin was fin	nished.				month then monthly to assure interventions for fall risk are			
			_			place as care planned.4. Re			
	' '	der from the Oncologis	st			from QA reviews will be			
		65, dated 10/13/11,				forwarded to the Facility Ris	<		
		b Elixir 15 ml per				Management Quality			
	G-tube (feeding	g tube) every 4 hours				Improvement (RMQI) comm	ttee		
	PRN for pain.	A column next to the				for further review and reccommendations, until 10	0%		
	physician order	r for the Lortab Elixir				compliance achieved times			
	had been mark	ked "do not send".				months.	-		
	A facility care p	olan for Resident #65,							
	dated 10/5/11,	indicated a problem o	f						
	alteration in co	mfort related to acute							
	pain episodes i	related to cancer with							
	goals to the pro	oblem included, but no	ot						
	limited to, will re	eport pain less than							
		xperience decreased							
		ce by verbalization of							
	decrease in pa	in. Approaches to the	,						
	· •	ed, but were not limite							
		signs and symptoms							
		dication per order and							
		veness, assess pain							
		(location, duration,							
		of 1-10], precipitating							
		rovide medication for							
		pain per physician							
	order.	F P P J I I I							
	,								
	A facility care p	olan for Resident #65,							
FORM CMS-2	567(02-99) Previous Version		ID: U7 1	K811	Facility II	D: 000250 If continuation s	heet Pa	ge 15 of 91	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
RIVERBE	END HEALTH CARI	E CENTER		VINCHESTER RD WAYNE, IN46819	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	dated 10/4/11, alteration in corpain due to car included, but not experience dec Approaches to but were not lin medication man monitor and report of drug to physical assess pain characteristic per effectiveness, a for break throughorder. Facility Care Track dated 10/4/11 a radiation burns. The Care Track mouth rated @ ordered awaitin. Facility Care Track dated 10/5/11 a complaint of particular complaint of particular complaint conneck et (and) recognition of particular conneck et (and) recognition in control of particular control of particula	indicated a problem of mfort related to chronic neer with a goal of limited to, will creased pain. The problem included, nited to, review pain nagement periodically, port effectivness (sic) ician as needed, gns and symptoms, aracteristics (location, sity [scale of 1-10] ctors), administrator order and assess and provide medication gh pain per physician Tack for Resident #65, at 6:00 p.m., indicated in neck open to air. It also indicated pain to (at) 8 and meds and delivery. Tack for Resident #65, at 7:00 p.m., indicated ain, medicated for pain. Tack for Resident #65, at 12:00 a.m., indicated (complaint of) pain to			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	F	STREET A	DDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CARI	E CENTER			INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	not in facility @ attempted to re emergency dru needed not ava contacted phar order of medicaresident reques pharmacy staff already in route pharmacy staff already in route pharmacy" Track indicated medicated for personal states of the s	etrieve medication from g kit but dosage ailable. Writer macy to request stat ation be sent out due to stWriter informed by that medication is from local At 1:30 a.m., the Care IResident pain as ordered" At a Track indicated the c/o pain/PRN en" The Care Track d the resident was of discomfort during ft, the 7A-3P shift, and ft. Intervention Flowsheet 55, for the month of indicated on 10/5/11 at ident #65 described his at of 10 on the pain p.m., Resident #65 ain remained an 8 out					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155359	B. WIN	G		10/24/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
DIV (EDD)		E OFNITED			INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORTV	VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG				TAG	DEFICIENCE!		DATE
		pain to neck et					
		medication. Resident request et order"					
		k further indicated the					
		aving periods of					
		ing 11P-7A shift and					
	the 3P-11P shi	•					
	A facility Pain I	ntervention Flowsheet					
		65, for the month of					
		indicated on 10/6/11 at					
	· · · · · · · · · · · · · · · · · · ·	ident #65 described his					
	· · · · · · · · · · · · · · · · · · ·	of 10 on the pain					
	scale. At 8:20	-					
	Intervention Flo	owsheet indicated the					
	pain medicatio	n was effective. At					
	12:00 p.m., Re	sident #65 described					
	his pain as a 6	out of 10 on the pain					
	scale. At 1:00	p.m., the Pain					
	Intervention Flo	owsheet indicated the					
	pain medicatio	n was effective.					
	1	rack for Resident #65,					
		at 1:00 p.m., indicated					
		pain to neck et mouth,					
		medication. Resident					
		request et order" At					
		e Track indicated					
		pain to mouth et neck					
		ain medication.					
		cated per request et					
		00 a.m., the Care					
		d "Res c/o throat et					
		t relived by routine					
	mouth rinse. F	PRN Vicodin given at					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/24/2	ETED	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	B. WIN		DDRESS, CITY, STATE, ZIP CODE		
					INCHESTER RD		
	END HEALTH CARI			l	VAYNE, IN46819		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
PREFIX TAG	this time" We the Care Track "medicated x (with) PRN Vice relief" The Condition indicated the respective periods of disconshift and 3P-11. Facility Care Track and the respective paint of the periods of disconshift and 3P-11. Facility Care Track and the periods of disconshift and 3P-11. Facility Care Track and the periods of disconshift and 3P-11. Care Track request PR mouth pain" Care Track request PR mouth pain, respective paint in face, the periods and	ith no time recorded, indicated 2 for throat pain codin. Admits to Care Track further esident was having omfort during 7A-3P		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
	the pain scale.						
	dated 10/9/11 a	rack for Resident #65, at 11:30 p.m., indicated PRN Vicodin for c/o					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		LDING	onstruction 00	(X3) DATE COMPL 10/24/2	ETED	
	PROVIDER OR SUPPLIER		 5TREET A	ADDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	3:30 a.m., the 0 "Res request jaw pain. Give 8:30 a.m., the 0 "Requested \ pain. 8 on pair neck. Vicodin at 9:00 p.m., the "c/o of pain a Medicated at the Care Track furt resident was had discomfort duri shift and 3P-11 A facility Pain I on Resident #6 October 2011, 8:30 a.m., Resipain as a 9 out scale. At 9:00 described his pain as a 9 out scale. At 9:00 described his pain scale. #65 described 10 on the pain Resident #65 described 10 o	ntervention Flowsheet 55, for the month of indicated on 10/9/11 at ident #65 described his of 10 on the pain a.m., Resident #65 vain as a 1 out of 10 on At 1:00 p.m., Resident his pain as a 9 out of scale. At 2:00 p.m.,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UZK811 Facility ID:

000250

If continuation sheet

Page 20 of 91

i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155359	B. WIN			10/24/2	011
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
RIVERBE	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
PREFIX TAG	station request Lidocaine. Giv 10:00 p.m., the "c/o of pain, \Care Track furt resident was hadiscomfort duri A facility Pain I for Resident #6 October 2011, for 10/10/11. Facility Care Track indicated 10/11/11 "Resident c/o neck. Resident et order" At Track indicated request pain m Physician notifi The Care Track indicated response had be physician. A facility Pain I for Resident #6 October 2011, at 8:45 a.m., R his pain as a 9 scale. At 9:45	ing PRN Vicodin et en as ordered" At Care Track indicated Vicodin given" The ther indicated the aving periods of ng the 11P-7A shift. Intervention Flowsheet 65, for the month of did not have an entry Track for Resident #65, at 4:00 a.m., indicated pain to L (left) face et medicated per request 12:00 p.m., the Care 12:00 p.m., the Care 13"Resident now redication for d/t pain. The did not indicated any peen received from the content of 10 on the pain a.m., Resident #65 out of 10 on the pain a.m., Resident #65 out of 10 on the pain a.m., Resident #65 out of 10 on the pain a.m., Resident #65 out of 10 on the pain a.m., Resident #65 out of 10 on the pain a.m., Resident #65 out of 10 on the pain a.m., Resident #65 out of 10 on the pain a.m., Resident #65 out of 10 on the pain a.m., Resident #65 out of 10 on		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION DATE
	Facility Care T	rack for Resident #65,					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155359	B. WIN			10/24/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		1	INCHESTER RD		
RIVERBE	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		l at 3:00 a.m., indicated					
		pain to L face et neck.					
		cated per request et					
		00 p.m., the Care Track					
		edicated with PRN pain					
		for c/o neck pain 7:30					
		n" At 3:30 p.m., the					
	Care Track ind						
	· •	N pain medication					
	PRN Vicodin	liquidgiven"					
	A facility Pain I	Intervention Flowsheet					
	for Resident #6	65, for the month of					
	October 2011,	indicated on 10/12/11					
	at 7:30 a.m., R	lesident #65 described					
	his pain as a 1	0 out of 10 on the pain					
	scale. At 8:30	a.m., Resident #65					
	described his p	pain as a 1 out of 10 on					
	the pain scale.	At 11:30 a.m.,					
	Resident #65 d	described his pain as a					
		the pain scale. At					
		sident #65 described					
	•	out of 10 on the pain					
		p.m., Resident #65					
		pain as an 8 out of 10					
		ale. At 5:00 p.m., the					
	•	on Flowsheet indicated					
		ation was effective.					
	Facility Care T	rack for Resident #65,					
	dated 10/13/11	at 6:00 a.m., indicated					
		pain to L cheek.					
		cated PRN pain as					
		9:00 a.m., the Care					
		d "Res returned from					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		ntment), seen by alled Oncologist					
		ification for Lortab Elixir					
		no time recorded, the					
		icated "Medicated c					
	Vicodin @ 4:30	p for c/o pain. Pain					
	rated 9 on scal	e 1-10"					
		ntervention Flowsheet					
		65, for the month of					
	•	indicated on 10/13/11					
		esident #65 described 8 out of 10 on the pain					
	•	a.m., the Pain					
		owsheet indicated the					
		n was effective.					
	'						
	Facility Care T	rack for Resident #65,					
		at 5:00 a.m., indicated					
		pain et requested pain					
		esident medicated per					
	•	er" At 8:00 a.m.,the					
		icated "c/o neck					
	medication"	I with PRN pain With no time					
		Care Track indicated					
	· · · · · · · · · · · · · · · · · · ·	or neck pain x 1"					
		k further indicated the					
		aving periods of					
		ng the 7A-3P shift.					
	_	ntervention Flowsheet					
		35, for the month of					
	· ·	indicated on 10/14/11					
	at 8:00 a.m., R	esident #65 described					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155359	A. BUI	LDING	00	COMPL 10/24/2	
		100009	B. WIN			10/24/20	011
NAME OF I	PROVIDER OR SUPPLIE	R		1	DDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		0 out of 10 on the pain		TAG	BETTOERNOTY		DATE
	scale. At 9:00	•					
		owsheet indicated the					
		n was effective.					
	Facility Care T	rack for Resident #65,					
	dated 10/15/11	1 at 12:00 p.m.,					
	indicated "Re	•					
	, ,	pain x 2 this shift.					
	Given PRN Vid	codin"					
	A facility Dain	Intervention Flouraboot					
		Intervention Flowsheet 35, for the month of					
		did not have an entry					
	for 10/15/11.	did flot flave all effility					
	101 107 107 11.						
	Facility Care T	rack for Resident #65,					
	1	l at 7:00 a.m., indicated					
	"Requested	PRN Vicodin x 1 for c/o					
	pain this a.m.	Given as ordered" At					
	· ·	Care Track indicated					
		in/medicated with PRN					
	1 '	At 6:00 p.m., the Care					
		d "Res a & o et c/o					
	1 '	fort. Vicodin given @					
		pain et neck" The ther indicated the					
		tner indicated the aving periods of					
		ing the 7A-3P shift and					
	the 3P-11P shi	_					
	A facility Pain	Intervention Flowsheet					
	,	65, for the month of					
	October 2011,	indicated on 10/16/11					
	at 12:00 a.m.,	Resident #65 described					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 10/24/20	ETED
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CARI	E CENTER			NCHESTER RD /AYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	a.m., no improve been noted. At #65 described 10 on the pain no improvemen noted. At 1:00 described his pon the pain medicated the pain medicated 10 on the pain medication. Tacility Care Trigory Care	owsheet indicated the n was effective. Tack for Resident #65, at 5:00 a.m., indicated ing PRN Vicodin for c/o n as ordered" At Care Track indicated odin for neck, head et n as per order" At Care Track indicated					

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00		(X3) DATE SU COMPLE 10/24/20	TED
NAME OF I	PROVIDER OR SUPPLIEF	• {		EET ADDRESS, CITY, STATE	E, ZIP CODE		
RIVERRI	END HEALTH CAR	F CENTER		9 WINCHESTER RD RT WAYNE, IN46819			
(X4) ID		TATEMENT OF DEFICIENCIES					(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFI			TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		ENCY)	16	DATE
	,	rack for Resident #65,					
		at 2:00 a.m., indicated					
		pain et requested pain esident medicated as					
		uested" With no time					
		Care Track indicated					
	"Resident red	quested Vicodin at					
		jaw et face pain"					
		ecorded, the Care					
		d "Medicated for L x 1" The Care					
	•	idicated the resident					
		riods of discomfort					
	during the 11P	-7A shift, 7A-3P shift					
	and the 3P-11F	Shift.					
	A facility Pain I	ntervention Flowsheet					
		35, for the month of					
	October 2011, for 10/18/11.	did not have an entry					
	101 10/18/11.						
	,	rack for Resident #65,					
		at 6:00 a.m., indicated					
		pain et requested pain At 9:00 p.m., the Care					
		d "Res a & o et c/o					
		fort @ this time. Pain					
	•	this shift" The Care					
		idicated the resident					
		riods of discomfort					
	_	3P shift and the 3P-11P					
	shift.						
	A facility Pain I	ntervention Flowsheet					
	-	65, for the month of					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED
	PROVIDER OR SUPPLIER		J. WIN	7519 W	DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN46819	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	October 2011, at 1:00 p.m., R his pain as a 10 scale. At 2:00 Intervention Flopain medication 6:00 p.m., Resipain as a 10 ou scale. At 8:00 described his pon the pain scale Resident #65 d 3 out of 10 on the pain scale at 10:20/11 "Resident c/c medication. Rerequest et order Care Track ind Tylenol for mound A facility Pain I for Resident #60 Care Track ind Tylenol for mound for Resident #60 Care Track ind Tylenol for Mound for Resident #60 Care Track ind Tylenol for Mound for Resident #60 Care Track ind Tylenol for Mound for Resident #60 Care Track ind Tylenol for Mound for Resident #60 Care Track ind Tylenol for Mound for Resident #60	indicated on 10/19/11 esident #65 described 0 out of 10 on the pain p.m., the Pain owsheet indicated the n was effective. At ident #65 described his it of 10 on the pain p.m., Resident #65 hain as a 3 out of 10. Resident #65 hain as a 10 out of 10 ille. At 10:30 p.m., lescribed his pain as a					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	
		155359	B. WIN			10/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				ODDRESS, CITY, STATE, ZIP CODE		
RIVERBE	END HEALTH CAR	ECENTER		FORT V	VAYNE, IN46819		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	PRN pain media.m., the Care to Oncologist of Lortab Elixir. Medication not facility physicia 5/500. Writer non medication (Continue to follorders Vicodin q (every) 4 hrs seen in office of received et not Care Track indi	In. Medicated with cation" At 11:00 Track indicated "call ffice r/t N.O. 10/13/11 ID informed that given. Order from n 10/12/11 for Vicodin equested clarification per office nurse. ow facility physician 5/500 mg 1 po (orally) PRN pain until resident n 10/25/11. Order ed" At 5:00 p.m., the icated "C/o neck pain Vicodin 5/500"					
	for Resident #6 October 2011, at 8:30 a.m., Re his pain as a 9 scale. At 10:00 described his p the pain scale. #65 described 10 on the pain the Pain Interve indicated the pa effective. At 5: described his p on the pain scale Pain Intervention	ntervention Flowsheet 15, for the month of 16 indicated on 10/21/11 16 esident #65 described 16 out of 10 on the pain 16 a.m., Resident #65 17 ain as a 2 out of 10 on 18 At 2:30 p.m., Resident 19 his pain as a 10 out of 19 scale. At 3:30 p.m., 19 ention Flowsheet 19 ain medication was 10 p.m., Resident #65 10 ain as a 10 out of 10 10 le. At 6:00 p.m., the 10 on Flowsheet indicated 10 ation was effective.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/24/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	₹	•		ADDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CAR	E CENTER			INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Resident #65, October 2011, at 7:30 a.m., R his pain as a 1 scale. At 8:30 described his pain scale. Resident #65 of 10 out of 10 or 1:30 p.m., Respain as a 3 out scale. At 4:30 described his pon the pain scale Resident #65 of 3 out of 10 on A Progress No dated 10/23/11 "Request Vicineck. Rated 1 as per order Care Track ind Vicodin for pain 10 on pain scale order" A Pain Interver Resident #65, October 2011, at 7:30 a.m., in described his pon the pain scale on the pain scale of the	ntion Flowsheet for for the month of indicated on 10/22/11 lesident #65 described 0 out of 10 on the pain a.m., Resident #65 pain as a 2 out of 10 on At 12:30 p.m., described his pain as a 1 the pain scale. At ident #65 described his is of 10 on the pain p.m., Resident #65 pain as a 10 out of 10 pale. At 6:00 p.m., described his pain as a the pain scale. It for Resident #65, at 12:30 a.m., indicated codin for pain in face et 0 on pain scale. Given at 12:00 p.m., the dicated "Requested in in neck et jaw. Rated le. Given as per indicated on 10/23/11 paidicated Resident #65 pain as a 10 out of 10 pale. At 9:00 a.m., indicated his pain was a mile. At 9:00 a.m., indicated his pain was a mile. At 9:00 a.m., indicated his pain was a mile.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155359		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/24/2011	
	ROVIDER OR SUPPLIER		STREET . 7519 W	ADDRESS, CITY, STATE, ZIP CODE /INCHESTER RD WAYNE, IN46819	
(X4) ID PREFIX	SUMMARY S	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	12:00 p.m., Reshis pain as a 10 scale. At 1:00 described his puthe pain scale. #65 described I 10 on the pain scale at 10 of 10 or p.m., Resident as a 10 of 10 or 9:30 p.m., the Flowsheet indication was A Pain Intervent Resident #65, for October 2011, at 7:30 a.m., Rehis pain as a 10 scale. At 10:00 described his puthe pain scale. During an observation of pain severe pain in Finistructed Resident Resident H65 at medication from severe pain in Finistructed Resident I but not yet been scale.	s effective. Intion Flowsheet for for the month of findicated on 10/24/11 resident #65 described of out of 10 on the pain of a.m., Resident #65 ain as a 3 out of 10 on findicated on the pain of a.m., and the pain of the pain of the pain of the pain of a.m., and the pain of the pai			

STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
7519 WINCHESTER RD RIVERBEND HEALTH CARE CENTER FORT WAYNE, IN46819	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-RELEXENSES OF THE ALT NOT NATE DEFICIENCY)	DATE
him a PRN pain med. The PRN pain	
medication for Acetaminophen 650	
mg was administrated at that time.	
Review of the Medication	
Administration Record for Resident	
#65 for the month of October 2011 on	
10/21/11 at 10:20 a.m., indicated the	
Lortab Elixir had not been added.	
Resident #65 was interviewed on	
10/21/11 at 10:46 a.m. During the	
interview he indicated he had	
constant pain in his left jaw. He also	
indicated the facility only gave him	
Tylenol which did not help with the	
pain.	
LPN #5 was interviewed on 10/21/11	
at 1:29 p.m. During the interview she	
indicated the nurse who recorded the	
order by the Oncologist had called	
Resident #65's facility physician to	
verify the order. LPN #5 also indicated the nurse on duty did not	
receive a call back from the primary	
physician regarding the order from	
Resident #65's Oncologist and	
marked do not send on the order	
form. LPN #5 further indicated the	
nurse failed to do any follow-up	
regarding the order for the Lortab Elixir, which was a stronger strength	
than the Vicodin. LPN #5 further	
indicated Resident #65's cognitive	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/24/2011
	PROVIDER OR SUPPLIER		STREET A 7519 W	ADDRESS, CITY, STATE, ZIP CODE VINCHESTER RD WAYNE, IN46819	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	status placed h oriented.	im as alert and			
	interviewed on During the inter	vices Director was 10/21/11 at 1:39 p.m. view she indicated vas considered alert			
	During the inter	10/24/11 at 8:38 a.m. rview she indicated the nave a policy on			
	During the interfacility physicia Lortab Elixir do different from the Vicodin. She as facility physicia increase the do based on Resid history with Vicofacility physicia the pain manage #65. She also had not receive	10/24/11 at 8:47 a.m. rview she indicated the n did not feel the se was that much			
	Oncologist and Resident #65's had not been re				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL	
		155359	B. WIN			10/24/2	011
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE		
DI\/EDRI	END HEALTH CARI	E CENTED			INCHESTER RD VAYNE, IN46819		
					VATIVE, IN40019		OV.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Director of Nur	sing indicated the					
	facility would be	e following the facility					
		r for the Vicodin until					
	Resident #65's next appointment with the Oncologist. She further indicated the order for the Lortab Elixir had been not been added to the MAR.						
	A Medical Onc	ology and Hematology					
	Report for Resident #65, dictated						
	10/16/11 and p	rovided by the					
	physician's offic	ce on 10/24/11 at					
	•	icated a diagnoses of					
		sive squamous cell					
		ne tongue, status post					
	hemiglossector	•					
	"The patient	e report also indicated					
	•	er than pain in his neck					
	•	the tumorHis neck					
		2-3 cm (centimeter)					
		terior triangle of lower					
	neck on the lef	t side, which is clearly					
	extensive tumo	rhe probably has					
		sethis will not be a					
	_	ancyHe had a lot of					
	pain in his mou	ıth"					
	2 The record for	or Resident #23 was					
		0/18/2011. Diagnoses					
		rere not limited to,					
	· ·	cerebellar ataxia, HTN					
	(hypertension),	dementia, traumatic					
	brain injury with	n expressive aphasia,					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155359	B. WIN			10/24/2	011
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R		7519 W	INCHESTER RD		
RIVERB	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	on dioxide poisoning,					
	anxiety, peptic ulcer, depression, psychosis, mood disorder, and benign prostatic hypertrophy.						
	A NA:::::::::::::::::::::::::::::::::::	A Minimum Data Set Assessment					
	dated 8/16/2011, indicated Resident						
	•	ently incontinent of					
		ired the extensive					
	assistance of c	one person for toileting.					
	A core plan for	Desident #22 with an					
	A care plan for Resident #23, with an on-set date of 5/16/2011 and a goal						
		•					
	date of 11/26/2	•					
		vas incontinent of					
	1	al was indicated as					
	•	performed with staff					
		ch incontinent episode					
	thru (sic) next						
		pproaches listed on the					
	•	ded, but were not					
		ck for incontinent					
	1 .	"assist to and from					
		re and after each meal					
	and prn (as ne	eded)."					
	Op 10/10/2014	at 1:40 D.M. Dacidant					
		at 1:40 P.M. Resident					
		ved sitting in his wheel					
		est lounge. His gray					
		ere observed to be wet					
	in the groin are	ea.					
	On 10/20/2011	, Resident #23 was					
		bserved in the West					
	1	30 A.M. until 12:00					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED
	PROVIDER OR SUPPLIER		STREET A	IDDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	sitting in a whe Resident #23 w down at his lap sweat pants was that time, the rest to propel himsel down the hall to was observed to minutes and the himself to the conservation per CNA #11 was in 10/20/2011 at interview, the CM #23 was incontinence cardindicated resident or check to ileted or check every two hours meals. The CM Resident #23 in because he did staff when he in CM 10/20/2011 continuously of lounge from 1:00 dressed in the sitting in his when he in the sitting in his					

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/O		(X2) MUI	LTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	C	A. BUILE	DING	00		COMPL	
		155359		B. WING				10/24/2	UII
NAME OF P	ROVIDER OR SUPPLIER					DDRESS, CITY, STA			
						NCHESTER RE			
	END HEALTH CAR	E CENTER			FORT W	/AYNE, IN4681	9		
(X4) ID		TATEMENT OF DEFICIENCI			ID		LAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY		P	REFIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORM	IATION)	┼	TAG	DEF	ICIENCY)		DATE
		.M., CNA #10 was							
	•	opel Resident #23 t							
		resident's sweat pa							
		was observed to be							
	saturated with	urine all the way do	own						
	his thighs. CNA	x #10 was interview	red .						
	at that time. Do	uring the interview,	the						
	CNA indicated the day shift CNA had								
	told her in report that she didn't check								
	the resident since he was in bingo.								
		as never observed							
		uring the observation							
	attoria biligo at	g and observation							
	The DON was	interviewed on							
		5 P.M. During the							
		ON indicated staff	fo.,						
	•	to check residents							
		toilet them every 2							
	•	ng on the needs of	the						
	resident. She for								
	residents were	to be toileted befor	e						
	A facility	لتاليت احتيما مور	المامة						
		on bowel and blac	ader						
		nagement, with a							
		f 8/2010, indicated							
	"Interventions a	•							
	maintain dignity	•							
	3. Review of the	ne clinical record fo	r						
	resident #5 on	10/19/11 at 9:30 a.	m.						
	indicated the re	esident was admitte	ed to						
	the facility on 6	/28/11 with diagnos	ses						
	including, but n	-							
	_	side, Diabetes,							
		d Hypertension.							
		Admission Minimum	1						
FORM CMS-2	567(02-99) Previous Version			 ZK811	Facility II	D: 000250	If continuation sh	neet Par	ge 36 of 91

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155350			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155359	B. WIN	G		10/24/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CARI	E CENTER			INCHESTER RD VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	,	s) assessment dated					
		d the resident had					
	functional limitation on one side of the upper and lower extremity.						
		or extremity.					
	Observation of	the resident on					
	10/17/11 at 11:	30 a.m. indicated the					
		her wheelchair and					
		s bent towards her left					
	shoulder. Her contracted. Int						
		17/11 at 11:45 a.m.					
		ad lived at a different					
	facility and had	a hand splint but had					
	not seen it sind	e coming to the new					
	facility.						
	On 10/19/11 of	9:30 a.m. review of					
		idmission orders dated					
		ed the resident was to					
		d splint during the day					
		nd replace with a					
		throughout the night as					
		n order to check skin					
		er splint applied to left					
		n and dry areas well					
	peiore and aπe	er splint application.					
	Interview with r	nurse # 6 on 10/18/11					
		ndicated she did not					
	know the reside	ent was to have a					
	hand/arm splin	•					
	observation of						
		0 p.m. the resident					
	had a hand/arn	n splint. Interview with					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED	
NAME OF I			b. Will		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	K			INCHESTER RD		
RIVERBE	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		that time indicated		TAG			DATE
		I the splint in her closet.					
		t the opinic in her diedet.					
	On 10/20/11 at	t 2:20 p.m. interview					
	with CNA # 4 a	and #7 indicated they					
	had never see	n the resident wear a					
	hand brace/spl	lint.					
	4 On 10/20/11	at 3:02 p.m., Resident					
		ved in her room, no					
		ted in the wheelchair.					
	On 10/24/11 at	t 9:10 a.m., Resident					
	#37 was obser	ved in bed. The					
		elchair was sitting					
		l with a pressure					
		on in the seat along					
	1	sling pad. No dycem					
	was observed.						
	Δ review of the	e clinical record for					
		on 10/17/11 at 2:30					
		a telephone order,					
		for dycem to be placed					
		37's wheelchair seat.					
		ange form, dated					
	· · · · · · · · · · · · · · · · · · ·	ted Resident #37 had					
		I from her wheelchair in					
	_	n. The form indicated					
	Resident #37 s	slipped oπ the at and was assisted to					
	the floor by sta						
	The hoor by sta	ш.					
	Nurse's Notes,	dated 1/15/11 at 11:30					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155359	B. WIN	IG		10/24/20	011
NAME OF I	PROVIDER OR SUPPLIEI	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORTV	VAYNE, IN46819		
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	· ·	Resident #37 was					
		floor after the resident heelchair. The note					
		ed the resident's hoyer					
		ved and dycem was					
	placed in the c	•					
	placed in the c	nun.					
	A facility care	olan Potential for Falls,					
		with a goal date of					
	11/29/11, did r	•					
	intervention of						
	wheelchair.	,					
	CNA #4 was in	terviewed on 10/24/11					
	at 9:10 a.m. D	uring the interview,					
	CNA #4 indica	ted Resident #37 used					
	to use dycem ((non-slip material) but					
	not anymore.	She further indicated					
	none was in th	e wheelchair currently,					
	just a cushion.						
	•	licy for Fall Risk					
		lanagement, dated					
	•	rided by the Director of					
	_	21/11 at 10:00 a.m.					
		ed the following: "The					
		y team works with the					
	resident/patien						
	and implement	ible party to identify					
	•	reduce the risk of falls					
	-	e maximizing dignity					
	plan to indicate	enceRevise the care					
	· ·	s indicatedModify					
	I interventions a	s mulcaleuiviouny					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED				
ANDILAN	or correction	155359	A. BUILDING	00	10/24/2011			
		10000	B. WING	DDDEGG CITY OTATE ZID CODE	10/2 1/2011			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD					
RIVERBE	END HEALTH CARE	CENTER		VAYNE, IN46819				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
		goals and interventions communicate changes ng team"						
F0309 SS=G	must provide the mean to attain or maintain physical, mental, as in accordance with assessment and placed on observe or desired to the follow a physicis medication for (Resident #65) for pain. This reference in the follow appropriate the follow appropriate the following appropr	rvation, interview and ne facility failed to an's order for pain	F0309	F 309 SS: G Provide Care/Services for highest we being.It is the policy of Rivert Health Care Center to compl with regulatory requirement Provide care/services for hig well being.1. Res#65 Facilit unable to apply specific corre action due to resident discharge.Res #23 re-assess	bend y hest ty is ective			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UZK811 Facility ID:

000250

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
ANDILAN	or correction	155359		LDING		10/24/2	
			B. WIN		DDDESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		o failed to ensure a			for bladder toileting plan and	care	
	hand splint was	s provided as ordered			plan as indicated.Res #5 is currently on therapy caseload	d for	
	for 1 of 3 reside	ents (Resident #5) who			evaluation and treatment for		
	met the criteria	for positioning.			application per MD order.2.	-	
					Facility has re-assessed curr	ent	
	Findings includ	le:			resident's pain and current		
					physicians orders for pain	io	
	Review of the	clinical record for			medication to ensure facility meeting residents	15	
	Resident #65 c	on 10/21/11 at 9:02			comfort needs.Facility has		
	a.m., indicated	the following:			conducted a review of reside	nts	
		uded, but were not			with adaptive equipment(spli		
	_	inoma of left tongue			per physicians order to ensur	re	
	with left cervica	U			present and appropriately		
		achexia (weight loss			applied.3. 3. Licensed staff re-educated on facility policy	and	
		sting), COPD (chronic			procedures related to: , adap		
		monary disease), HTN			equipment, physician orders		
		, and osteoarthritis.			pain management.Facility (ID		
	(Hyperterision),	, and osteoartimus.			will review new physician ord		
	Δ nhysician ord	der from the Oncologist			residents with new onset pair significant changes in conditi		
		65, dated 10/4/11,			new assitive/splints application		
		b Elixir 7.5/500 mg 15			the daily clinical meeting and		
		every 4 hours PRN (as			update care plan as		
	needed) for pa	•			indicated.Pain assessments		
	i needed) idi pa				be completed every shift and		
	A facility physic	nian order for Posident			documentation on the reside medication administration red		
	1	cian order for Resident			to ensure residents needs	301 G	
		7/11, indicated a			met.DON or designee will QA	A	
	Fentanyl patch	_			new admission pain assessm		
		er hour) once every			and physician orders for pain		
		pain. PRN (as needed)			medication to ensure availab of pain medication and	iiity	
	pain medication				effectiveness of pain medica	tion x	
	•	n 325-650 every 4			3 months.DON or designee v		
	1	RN, Acetaminophen			QA residents with adaptive		
		rams) per feeding tube			devices (splints) by completing	-	
	PRN and Lidoo	caine HCl 2% orally			random visual observation da		
					2 weeks then weekly x 4 the	FT1	

		X1) PROVIDER/SUPPLIE		(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMB	SEK:	A. BUILI	DING	00	_	COMPL	
		155359		B. WING	_			10/24/2	.011
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
DI\/EDD	END HEALTH CARE	= CENTED		7519 WINCHESTER RD FORT WAYNE, IN46819					
				igspace		VALINE, IIN40019 ———————————————————————————————————			
(X4) ID		TATEMENT OF DEFICIEN		.	ID	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED LISC IDENTIFYING INFOR			PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)		TE	COMPLETION DATE
1110		every 4 hours PR		+-	0	monthly to ensure ac	laptive		DILL
		order did not indic				devices are applied p		ician	
		as receiving the L				order.4. Results from	n QA rev	views	
		ed by the Oncolog				will be forwarded to the Rick Management O		lity	
		and onlooning	,		l	Risk Management Q Improvement (RMQI	-	ttee	
	An Admission M	Medical History of	F		l	for further review and]
		ination written by				reccommendations,			
		in for Resident #6			l	compliance is achiev	ed time:	s 3]
	, , ,	history of any dr	-			months.			
	use"	<i>y</i> = 2, 2	J		l]
					l				
	A facility physic	cian order for Res	ident						
		12/11, indicated to							
		mg orally every 4]
		hen current supp]
	Vicodin was fin		-]
]
	A physician ord	der from the Onco	ologist						
		65, dated 10/13/1	•						
	indicated Lortal	b Elixir 15 ml per							
	, ,	g tube) every 4 ho]
		A column next to							
		r for the Lortab El							
	had been mark	ced "do not send".	ı						
		olan for Resident			l				
	· ·	indicated a proble			l				
		mfort related to a							
	1 '	related to cancer							
		oblem included, b							
	· ·	eport pain less th							
		xperience decrea							
	1 '	ce by verbalizatio			l				
	-	in. Approaches to							
	problem include	ed, but were not l	ımited	<u> </u>					<u> </u>
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete	Event ID: UZ	ZK811	Facility II	D: 000250 If cor	ntinuation sl	heet Pa	ge 42 of 91

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE : COMPL		
		155359	A. BUI B. WIN	LDING G		10/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	END HEALTH CAR				INCHESTER RD VAYNE, IN46819		
					VATINE, 11140019		(115)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		signs and symptoms,					
		lication per order and					
		reness, assess pain					
		(location, duration, of 1-10], precipitating					
	,	ovide medication for					
		pain per physician					
	order.	· · ·					
	Δ facility care n	lan for Resident #65,					
		indicated a problem of					
	· · · · · · · · · · · · · · · · · · ·	mfort related to chronic					
	pain due to car	cer with a goal					
		ot limited to, will					
	experience dec	-					
	' '	the problem included,					
		nited to, review pain nagement periodically,					
		port effectivness (sic)					
	·	ician as needed,					
		ins and symptoms,					
	<u> </u>	aracteristics (location,					
	· ·	sity [scale of 1-10]					
	l · · · · •	ctors), administrator order and assess					
	· ·	and provide medication					
		gh pain per physician					
	order.	-					
	Facility Care Tr	rack for Resident #65,					
		at 6:00 p.m., indicated					
		in neck open to air.					
		calso indicated pain to					
	_	(at) 8 and meds					
	ordered awaiting	ig delivery.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155359	B. WIN			10/24/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		7519 W	INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	rack for Resident #65,					
		at 7:00 p.m., indicated					
	complaint of pa	ain, medicated for pain.					
	Facility Care T	rack for Resident #65,					
	dated 10/5/11	at 12:00 a.m., indicated					
	"resident c/o	(complaint of) pain to					
	neck et (and) r	equested pain					
	medication. Re	esident pain medication					
		(at) this time. Writer					
		etrieve medication from					
		ig kit but dosage					
	needed not ava						
		macy to request stat					
	•	ation be sent out due to					
		stWriter informed by					
	ı ·	f that medication is					
	already in route						
	l ·	At 1:30 a.m., the Care					
	Track indicated						
	medicated for	pain as ordered" At					
	9:30 a.m., Car	e Track indicated					
	"Resident wit	th c/o pain/PRN					
	medication give	en" The Care Track					
	further indicate	ed the resident was					
	having periods	of discomfort during					
	•	ift, the 7A-3P shift, and					
	the 3P-11P shi	-					
	A facility Pain I	Intervention Flowsheet					
	_	35, for the month of					
		•					
		indicated on 10/5/11 at					
		ident #65 described his					
	pain as a 10 oi	ut of 10 on the pain					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		A. BUILI	DING	NSTRUCTION 00	(X3) DATE COMPI 10/24/2	LETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE		.011
RIVERBI	END HEALTH CAR	E CENTER			NCHESTER RD /AYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
		p.m., Resident #65 ain remained an 8 out in scale.					
	dated 10/6/11 a "Resident correquested pain medicated per 6:00 a.m., the 0 "Resident c/orrequested pain medicated per The Care Trackresident was harman and the corresident was harman and the corresponding to the corre	rack for Resident #65, at 1:00 a.m., indicated implained of pain et medication. Resident request et order" At Care Track indicated pain to neck et medication. Resident request et order" It further indicated the aving periods of ing 11P-7A shift and ft.					
	for Resident #6 October 2011, 7:20 a.m., Resipain as a 6 out scale. At 8:20 Intervention Flopain medication 12:00 p.m., Rehis pain as a 6 scale. At 1:00 Intervention Flopain medication Facility Care Tridated 10/7/11 a	owsheet indicated the n was effective. At sident #65 described out of 10 on the pain p.m., the Pain owsheet indicated the					

000250

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	medicated per 5:00 p.m., Care "Resident c/c et requested par Resident medicorder" At 9:0 Track indicated mouth pain not mouth rinse. P this time" We the Care Track "medicated x (with) PRN Vice relief" The Condicated the reperiods of disconshift and 3P-11 Facility Care Track request PR mouth pain" Care Track request PR mouth pain" Care Track request PR mouth pain, resident was had discomfort duri 3P-11P shift.	cated per request et 200 a.m., the Care 1 "Res c/o throat et 2 relived by routine 2 PRN Vicodin given at 2 for throat pain c 2 for throat pain c 2 for throat pain c 3 for 2 for throat pain c 3 for 3 fo						
	ioi Resident#6	65, for the month of						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	-	indicated on 10/8/11 at sident #65 described					
	•	of out 10 on the pain					
	•	0 a.m., Resident #65					
		pain as a 1 out of 10 on					
	the pain scale.						
	and pain ocard.						
	Facility Care T	rack for Resident #65,					
	•	at 11:30 p.m., indicated					
	"Res request	PRN Vicodin for c/o					
	jaw pain. Give	n as ordered" At					
	3:30 a.m., the	Care Track indicated					
	"Res request	PRN Vicodin for c/o					
		n as ordered" At					
		Care Track indicated					
	· ·	Vicodin elx (elixir) for					
		n scale. Pain in face et					
		given as per order"					
	•	ne Care Track indicated					
	•	at 5 pm et 9 pm.					
		nese times" The ther indicated the					
		aving periods of					
		ing 11P-7A shift, 7A-3P					
	shift and 3P-11	•					
	A facility Pain I	ntervention Flowsheet					
	•	65, for the month of					
		indicated on 10/9/11 at					
	8:30 a.m., Res	ident #65 described his					
	pain as a 9 out	of 10 on the pain					
	scale. At 9:00	a.m., Resident #65					
		pain as a 1 out of 10 on					
	•	At 1:00 p.m., Resident					
	#65 described	his pain as a 9 out of					

000250

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00		E SURVEY PLETED /2011	
		100009	B. WING			2011
NAME OF P	ROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP CO	ODE	
DI\/EDRE	END HEALTH CARI	E CENTER		VINCHESTER RD WAYNE, IN46819		
				VVATIVE, IIV 4 0019		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE AF		COMPLETION DATE
TAG		<u> </u>	TAG			DATE
	•	scale. At 2:00 p.m., lescribed his pain as a				
	2 out of 10 on t	·				
	2 001 01 10 011 1	rie pairi scale.				
	Facility Caro Ti	rack for Resident #65,				
	_	at 1:00 a.m., indicated				
		urses station requesting				
	•	or c/o jaw pain. Given				
		At 6:00 a.m., the Care				
		I "Res up at nurses				
		ing PRN Vicodin et				
	•	en as ordered" At				
		Care Track indicated				
	•	Vicodin given" The				
	•	ther indicated the				
		aving periods of				
		ng the 11P-7A shift.				
		ing the Tit 77 office.				
	A facility Pain I	ntervention Flowsheet				
	•	55, for the month of				
		did not have an entry				
	for 10/10/11.	and not have an enaly				
	10, 10, 10, 11.					
	Facility Care Ti	rack for Resident #65,				
	•	at 4:00 a.m., indicated				
		pain to L (left) face et				
		medicated per request				
		12:00 p.m., the Care				
		I "Resident now				
		edication for d/t pain.				
		ed waiting reply"				
	_	k did not indicated any				
		peen received from the				
	physician.					
)					

000250

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL	ETED
		155359	B. WIN			10/24/2	011
NAME OF I	PROVIDER OR SUPPLIEF	\ \			DDRESS, CITY, STATE, ZIP CODE		
חו/רחחו		E CENTED			INCHESTER RD VAYNE, IN46819		
	END HEALTH CARI			l	VATINE, IN40019		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		•		IAG			DATE
	A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/11/11						
		esident #65 described					
		out of 10 on the pain					
	•	a.m., Resident #65					
		pain as a 1 out of 10 on					
	the pain scale.						
	Facility Care Ti	rack for Resident #65,					
	1	at 3:00 a.m., indicated					
		pain to L face et neck.					
		cated per request et					
	order" At 2:0	0 p.m., the Care Track					
	indicated "Me	edicated with PRN pain					
	medication x 2	for c/o neck pain 7:30					
	am et 11:30 an	n" At 3:30 p.m., the					
	Care Track ind	icated "Res					
	requested PRN	I pain medication					
	PRN Vicodin	liquidgiven"					
	•	ntervention Flowsheet					
		65, for the month of					
	1	indicated on 10/12/11					
	-	esident #65 described					
	•	0 out of 10 on the pain					
		a.m., Resident #65					
	-	pain as a 1 out of 10 on					
		At 11:30 a.m.,					
		lescribed his pain as a					
		the pain scale. At					
	•	sident #65 described					
		out of 10 on the pain					
		p.m., Resident #65					
	described his p	pain as an 8 out of 10					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 10/24/20	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	'	STREET AI	DDRESS, CITY, STATE, ZIP CODE		
	END HEALTH CARI				NCHESTER RD /AYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES	<u> </u>	ID T	ATNL, IN40019		(7/5)
PREFIX		CY MUST BE PERCEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	•	ale. At 5:00 p.m., the					
		on Flowsheet indicated					
	the pain medic	ation was effective.					
	Facility Care Track for Resident #65,						
	_	at 6:00 a.m., indicated					
		pain to L cheek.					
		cated PRN pain as					
		9:00 a.m., the Care					
		ntment), seen by					
		alled Oncologist					
	requesting clar	ification for Lortab Elixir					
		no time recorded, the					
		icated "Medicated c					
	rated 9 on scal	o 1 10 "					
	Taled 9 on scar	e 1-10					
	A facility Pain I	ntervention Flowsheet					
	for Resident #6	35, for the month of					
	· ·	indicated on 10/13/11					
	-	esident #65 described					
	-	8 out of 10 on the pain 0 a.m., the Pain					
		owsheet indicated the					
		n was effective.					
	1	rack for Resident #65,					
		at 5:00 a.m., indicated					
		pain et requested pain esident medicated per					
		er" At 8:00 a.m.,the					
		icated "c/o neck					
	pain/medicated	l with PRN pain					
	medication"	With no time					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	recorded, the Care Track indicated "Medicated for neck pain x 1" The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift.						
	1	ntervention Flowsheet					
		65, for the month of					
	•	indicated on 10/14/11					
	-	esident #65 described 0 out of 10 on the pain					
	scale. At 9:00						
		owsheet indicated the					
		n was effective.					
	Facility Care To	rack for Resident #65,					
	dated 10/15/11	•					
	indicated "Re	` '					
	,	pain x 2 this shift.					
	Given PRN Vic	coain"					
	A facility Pain I	ntervention Flowsheet					
	•	65, for the month of					
		did not have an entry					
	for 10/15/11.	·					
	1	rack for Resident #65,					
		at 7:00 a.m., indicated					
	-	PRN Vicodin x 1 for c/o Given as ordered" At					
	•	Care Track indicated					
	· ·	in/medicated with PRN					
		At 6:00 p.m., the Care					
	•	d "Res a & o et c/o					
	pain et discom	fort. Vicodin given @					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155359		A. BUI	LDING	onstruction 00	(X3) DATE COMPL 10/24/2	ETED	
		100000	B. WIN		ADDRESS CITY STATE ZIR CODE	10/24/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		pain et neck" The ther indicated the					
		aving periods of					
		ing the 7A-3P shift and					
	the 3P-11P shi	•					
	A facility Pain I	ntervention Flowsheet					
		65, for the month of					
	October 2011,	indicated on 10/16/11					
	at 12:00 a.m.,	Resident #65 described					
	-	0 out of 10. At 1:00					
		vement in pain had					
		t 9:00 a.m, Resident					
		his pain as a 10 of out					
	•	scale. At 10:00 a.m.,					
	=	nt in pain had been					
		p.m., Resident #65					
	-	pain as a 10 out of 10					
	•	ale. At 2:00 p.m., the on Flowsheet indicated					
		ation was effective. At					
	· •	ident #65 described his					
		ut of 10 on the pain					
	scale. At 7:00	•					
		owsheet indicated the					
	pain medicatio	n was effective.					
	Facility Care T	rack for Resident #65,					
	_	at 5:00 a.m., indicated					
	"Res request	ing PRN Vicodin for c/o					
	jaw pain. Give	n as ordered" At					
	10:00 a.m., the	Care Track indicated					
	"Request Vic	odin for neck, head et					
	jaw pain. Give	n as per order" At					
	3:30 p.m., the	Care Track indicated					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155359	A. BUI B. WIN	LDING G		10/24/2	011
NAME OF F	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
RIVERRE	END HEALTH CARI	- CENTER			INCHESTER RD VAYNE, IN46819		
(X4) ID		FATEMENT OF DEFICIENCIES		ID ID	W/ (1142, 11410010		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFICIONOSA		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	"Medicated for pain. Again medicated at 7:30 pm for jaw pain. C/o H/A (headache) did medicate c Tylenol"						
	1	ntervention Flowsheet					
		5, for the month of did not have an entry					
	for 10/17/11.	uid flot flave all effiliy					
	,	rack for Resident #65,					
		at 2:00 a.m., indicated					
		pain et requested pain esident medicated as					
		ested" With no time					
	· ·	Care Track indicated					
		juested Vicodin at					
		jaw et face pain"					
		corded, the Care I "Medicated for L					
		x 1" The Care					
	•	dicated the resident					
		iods of discomfort					
		-7A shift, 7A-3P shift					
	and the 3P-11F	· 511111.					
	A facility Pain I	ntervention Flowsheet					
		5, for the month of					
		did not have an entry					
	for 10/18/11.						
	Facility Care Tr	ack for Resident #65,					
		at 6:00 a.m., indicated					
		pain et requested pain					
	medication"	At 9:00 p.m., the Care					

NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER RIVERBEND HEALTH CARE CENTER SIMBLE AND MINIMARY STATIMENT OF DIPLEMENTIAL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL RECREATORY OR LSC IDENTIFY MIST BE PRECIDED BY PULL TAG Track Indicated " Res a & o et c/o pain et discomfort & the Precipion of the Pain meds given x 2 this shift" The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift and the 3P-11P shift. A facility Pain Intervention Flowsheet for Resident #65 described his pain as a 10 out of 10 on the pain scale. At 2:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 6:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale Facility Care Track for Resident #65, dated 10/20/11 at 5:00 a.m., indicated "Resident c/o pain et requested pain medication. Resident medicated per request et order" At 2:00 p.m., the Care Track indicated "Given PRN Tylenol for mouth discomfort"	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED	
RIVERBEND HEALTH CARE CENTER IXAI ID SUMMARY STATEMENT OF DEFICIENCIES GACH DEPERCENCY MUST BE PERCEDED BY FULL TAG Track indicated "Res a & o et c/o pain et discomfort @ this time. Pain meds given x 2 this shift" The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift and the 3P-11P shift. A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/19/11 at 1:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 2:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 6:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:00 p.m., Resident #65 described his pain as a 3 out of 10. At 10:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. Facility Care Track for Resident #65, dated 10/20/11 at 5:00 a.m., indicated "Resident c/o pain et requested pain medication. Resident medicated per request et order" At 2:00 p.m., the Care Track indicated "Given PRN	NAME OF I	PROVIDER OR SUPPLIEI	\					
PRETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Pain et discomfort @ this time. Pain meds given x 2 this shift" The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift and the 3P-11P shift. A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/19/11 at 1:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 2:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 6:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:00 p.m., Resident #65 described his pain as a 3 out of 10. At 10:00 p.m., Resident #65 described his pain as a 3 out of 10. At 10:00 p.m., Resident #65 described his pain as a 3 out of 10. At 10:00 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale.	RIVERBE	END HEALTH CAR	E CENTER					
pain et discomfort @ this time. Pain meds given x 2 this shift" The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift and the 3P-11P shift. A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/19/11 at 1:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 2:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 6:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:00 p.m., Resident #65 described his pain as a 3 out of 10. At 10:00 p.m., Resident #65 described his pain as a 3 out of 10. At 10:00 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. Facility Care Track for Resident #65, dated 10/20/11 at 5:00 a.m., indicated "Resident c/o pain et requested pain medication. Resident medicated per request et order" At 2:00 p.m., the Care Track indicated "Given PRN	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
A facility Pain Intervention Flowsheet		pain et discommeds given x 2 Track further ir was having per during the 7A-3 shift. A facility Pain If for Resident #6 October 2011, at 1:00 p.m., Resident as a 1 scale. At 2:00 Intervention Flopain medication 6:00 p.m., Resident #6 pain as a 10 or scale. At 8:00 described his pain as a 10 or scale. At 8:00 for the pain scale at 10:00 p.m., fescribed his pain as a 10 or scale at 8:00 for the pain scale at 10:00 p.m., fescribed his pain scale	fort @ this time. Pain 2 this shift" The Care indicated the resident riods of discomfort 3P shift and the 3P-11P antervention Flowsheet 55, for the month of indicated on 10/19/11 esident #65 described 0 out of 10 on the pain p.m., the Pain powsheet indicated the in was effective. At ident #65 described his at of 10 on the pain p.m., Resident #65 pain as a 3 out of 10. Resident #65 pain as a 10 out of 10 pale. At 10:30 p.m., described his pain as a the pain scale. Track for Resident #65, at 5:00 a.m., indicated pain esident medicated per er" At 2:00 p.m., the icated "Given PRN outh discomfort"					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155359	B. WIN	IG		10/24/2	011
NAME OF I	PROVIDER OR SUPPLIE	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
WHILE OF I	ROVIDER OR SOLVEIL			7519 W	INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		65, for the month of					
		indicated on 10/20/11					
	at 10:30 a.m., Resident #65 described his pain as a 9 out of 10 on the pain						
		0 a.m., Resident #65					
		pain as a 2 out of 10 on					
	the pain scale.						
	 Facility Care T	rack for Resident #65,					
	1	at 8:30 a.m., indicated					
		in. Medicated with					
		ication" At 11:00					
	•	Track indicated "call					
		office r/t N.O. 10/13/11					
	_	MD informed that					
		given. Order from					
		an 10/12/11 for Vicodin					
	1	requested clarification					
		per office nurse.					
		low facility physician					
		5/500 mg 1 po (orally)					
		PRN pain until resident					
		on 10/25/11. Order					
	received et not	ted" At 5:00 p.m., the					
	Care Track ind	licated "C/o neck pain					
		Vicodin 5/500"					
	1	Intervention Flowsheet					
		65, for the month of					
		indicated on 10/21/11					
		esident #65 described					
		out of 10 on the pain					
		0 a.m., Resident #65					
	-	pain as a 2 out of 10 on					
	the pain scale.	At 2:30 p.m., Resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UZK811 Facility ID:

000250

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		LETED
		155359	B. WIN			10/24/	2011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD	3	
RIVERBI	END HEALTH CAR	E CENTER			INCHESTER RD VAYNE, IN46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	TON	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		his pain as a 10 out of					
	10 on the pain scale. At 3:30 p.m., the Pain Intervention Flowsheet indicated the pain medication was						
		00 p.m., Resident #65					
	·	pain as a 10 out of 10					
		ale. At 6:00 p.m., the					
		on Flowsheet indicated					
	ine pain medic	ation was effective.					
	A Pain Interver	ntion Flowsheet for					
		for the month of					
	· ·	indicated on 10/22/11					
	-	esident #65 described					
	· ·	0 out of 10 on the pain					
	-	a.m., Resident #65					
		pain as a 2 out of 10 on					
		At 12:30 p.m.,					
		lescribed his pain as a					
	10 out of 10 or	the pain scale. At					
	1:30 p.m., Res	ident #65 described his					
	pain as a 3 out	of 10 on the pain					
	scale. At 4:30	p.m., Resident #65					
		pain as a 10 out of 10					
	on the pain sca	ale. At 6:00 p.m.,					
	Resident #65 o	lescribed his pain as a					
	3 out of 10 on	the pain scale.					
	A Progress No	te for Resident #65,					
	_	at 7:30 a.m., indicated					
		odin for pain in face et					
	•	0 on pain scale. Given					
		" At 12:00 p.m., the					
		icated "Requested					
		n in neck et jaw. Rated					

000250

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(.	X2) MUL	TIPLE CO	NSTRUCTION 00		(X3) DATE COMPL	
MOLLAN	155359			A. BUILD	ING			10/24/2	
		100000		B. WING				10/24/2	011
NAME OF P	ROVIDER OR SUPPLIER	2				DDRESS, CITY, STA			
DI) /EDD	- NID LIE AL TIL OAD!	E OFNITED				INCHESTER RI			
RIVERBE	END HEALTH CARE	E CENTER			FORTV	VAYNE, IN4681	9		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			ID	PROVIDER'S P	LAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		Pl	REFIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			TAG	DEF	ICIENCY)		DATE
	10 on pain scal	le. Given as per							
	order"								
	order" A Pain Interver Resident #65, for October 2011, at 7:30 a.m., indescribed his pon the pain scale Resident #65 in 2 out of 10 on to 12:00 p.m., Reshis pain as a 10 scale. At 1:00 described his pon the pain scale. #65 described 10 on the pain scale. #65 described 10 on the pain Resident #65 do 2 out of 10 on to p.m., Resident as a 10 of 10 on 9:30 p.m., the Form Flowsheet indication was A Pain Interver Resident #65, for October 2011, at 7:30 a.m., Rehis pain as a 10 of 10 on the pain scale.	ntion Flowsheet for for the month of indicated on 10/23/11 dicated Resident #65 pain as a 10 out of 10 pale. At 9:00 a.m., andicated his pain was a the pain scale. At sident #65 described 0 out of 10 on the pain p.m., Resident #65 pain as a 2 out of 10 on At 4:15 p.m., Resident his pain as a 10 out of scale. At 5:00 p.m., the pain scale. At 8:15 pain as a the pain scale. At 8:15 pain the pain scale. At Pain Intervention cated the pain							
	described his p	pain as a 3 out of 10 on							
	the pain scale.								
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	UZŁ	<811	Facility I	D: 000250	If continuation sh	eet Pa	ge 57 of 91

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	155359			LDING	00	10/24/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R		1	INCHESTER RD		
RIVERBE	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)		TAG	BEFFEERET		DATE
	During an observation of Resident #65 on 10/20/11 at 3:30 p.m., Resident #65 approached the East						
	med cart and re						
		m LPN #3 due to					
	severe pain in	his left jaw. LPN #3					
	instructed Resi	ident #65 his new					
		pain had been ordered					
		en sent from pharmacy					
		only be able to give					
	<u>-</u>	n med. The PRN pain					
		Acetaminophen 650					
	mg was admini	istrated at that time.					
	Review of the I	Medication					
	Administration	Record for Resident					
	#65 for the mo	nth of October 2011 on					
		:20 a.m., indicated the					
	Lortab Elixir ha	nd not been added.					
	Resident #65 v	vas interviewed on					
	10/21/11 at 10:	:46 a.m. During the					
	interview he ind	dicated he had					
		n his left jaw. He also					
		acility only gave him					
	l -	did not help with the					
	pain.						
	LPN #5 was in	terviewed on 10/21/11					
	at 1:29 p.m. During the interview she indicated the nurse who recorded the order by the Oncologist had called Resident #65's facility physician to						
	verify the order						
	indicated the n	urse on duty did not					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	PROVIDER OR SUPPLIER	8			INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		*		TAG	DEFICIENCY)		DATE
	receive a call back from the primary physician regarding the order from Resident #65's Oncologist and						
		send on the order					
		further indicated the					
		do any follow-up					
		order for the Lortab					
		as a stronger strength					
		n. LPN #5 further					
	indicated Resid	dent #65's cognitive					
	status placed h	im as alert and					
	oriented.						
		vices Director was					
		10/21/11 at 1:39 p.m.					
	_	rview she indicated					
		vas considered alert					
	and oriented.						
	The Director of	Nursing was					
	interviewed on	10/24/11 at 8:38 a.m.					
		rview she indicated the					
	1	nave a policy on					
	following physi	cian orders.					
	The Director of	Nursing was					
	interviewed on	10/24/11 at 8:47 a.m.					
	During the inte	rview she indicated the					
		n did not feel the					
		se was that much					
		he order for the					
		ilso indicated the					
		n did not want to					
		ose of the Vicodin					
	based on Resid	dent #65's previous					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED	
	PROVIDER OR SUPPLIER		J. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN46819	I <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	history with Violatic facility physicial the pain manage #65. She also had not receive the order for the Oncologist and Resident #65's had not been rethe facility as on Director of Nurse facility would be physician order Resident #65's the Oncologist. The Oncologist the order for the been not been A Medical Oncologist. The Oncologist for Resident #65's the Oncologist. The Oncologist for Resident #65's p.m., independent of the Oncologist for Resident #65's p.m., independent for Resident f	n would take care of gement for Resident indicated the facility ed any clarification on e Lortab Elixir from the his notes from 10/13/11 appointment ecorded and sent to f this date. The sing indicated the e following the facility of for the Vicodin until next appointment with She further indicated e Lortab Elixir had added to the MAR. I cology and Hematology ident #65, dictated rovided by the ce on 10/24/11 at icated a diagnoses of sive squamous cell ne tongue, status post my and neck ereport also indicated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

S, CITY, STATE, ZIP CODE	
ESTER RD E, IN46819	
ESTER RD	(X5) COMPLETION DATE
	H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE COMPL	
THINDTEIN	or condection	155359	- 1	LDING		10/24/2	
		100000	B. WIN		DDDECC CITY CTATE 7ID CODE	10/2 1/2	
NAME OF F	PROVIDER OR SUPPLIER	₹		1	DDRESS, CITY, STATE, ZIP CODE		
RIVERBE	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		9:30 a.m. review of					
		admission orders dated					
		ed the resident was to					
		d splint during the day					
	-	and replace with a					
		throughout the night as					
	· · · · · · · · · · · · · · · · · · ·	an order to check skin					
		er splint applied to left					
		n and dry areas well					
	before and after	er splint application.					
	Intomiovy with m						
		nurse # 6 on 10/18/11 Indicated she did not					
		ent was to have a					
	hand/arm splin	the resident on					
		0 p.m. the resident n splint. Interview with					
		that time indicated					
		the splint in her closet.					
	Stair flad fourid	the spilit in her closet.					
	On 10/20/11 at	: 2:20 p.m. interview					
		and #7 indicated they					
		n the resident wear a					
	hand brace/spl						
	l land blace/spi						
	3.1-37(a)						
	3 3. (a)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155359	B. WING	G		10/24/2	011
	PROVIDER OR SUPPLIER			7519 WI	DDRESS, CITY, STATE, ZIP CODE NCHESTER RD /AYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0311 SS=D	and services to ma abilities specified is section. Based on record the facility failed therapy as door MDS for 1 of 5 #53) who met to of daily living. Findings includ Resident #53's on 10/19/11 at indicated Residincluded, but word congestive hear mellitus, and congestive hear mellitus hear mellitus hear mellitus hear mellitus hear	record was reviewed 10:10 a.m. The record lent #53's diagnoses ere not limited to, rt failure, diabetes erebrovascular or decreased range of 0/1/11, with a goal date licated Resident #53 te in a restorative not addressed the r restorative l transfers in the	F0	311	F 311 SS: D Treatment/Servito maintain ADL'sIt is the policitation of the policy requirement treatment/service maintain ADL's.1. Res # 53 re-assessed by nursing for appropriate restorative plan. #53 screen by therapy for additional restorative interver as appropriate.2. Facility nur will review resident last two Massessments and compare for decline in function per MDS section G, if decline is noted resident's will be referred to therapy for screen to determine restorative program would be beneficial to resident.3. Lice staff re-educated on facility pland procedures related to: restorative program. The IDT review in daily clinical meeting residents who have a function decline and will refer to therator screening for restorative programming. DON or design will QA restorative document weekly x 3 months to ensure restorative program complete per physician order and documented accurately.4. Results from QA reviews will forwarded to the Facility Risk	Res ntion raing MDS or a then ne if e nsed olicy will g nal py ee ation that ed be	11/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155359	B. WIN	G		10/24/201	11
NAME OF F	PROVIDER OR SUPPLIEF		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
TWINE OF T	ROVIDER OR SOLVER			7519 W	INCHESTER RD		
RIVERBE	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID	SUMMARY S	MARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
TAG	The annual Mirassessment, de Resident #53 restorative trans. The restorative trans. The restorative trans. The restorative trans. Wanager on 10 The document: #53 as having transfer restorative ther 10/24/11 was ported for the MDS nurse therapy for Restorative, the MDS and he amount of preceives. She restorative ther documentation of therapy. We sessions of restorative of the manual ma	ation listed Resident an ambulation and ative program. umentation of rapy from 8/26/11 until provided by the Director 10/24/11 at 1:40 p.m. documentation in the ting of any restorative sident #53. e was interviewed on 0 p.m. During the MDS nurse indicated now it is coded affects payment the facility further indicated for rapy, there must be of at least 15 minutes nen there is at least two storative [days], this		TAG	Management Quality Improvement (RMQI) commi for further review and reccommendations, until 100 compliance is achieved times months.	ttee	DATE
	would increase	the "RUG" category					
	[amount of mo	ney the facility would					
	receive].						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155359	B. WING	10/24/2011	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE VINCHESTER RD	
RIVERBE	END HEALTH CARE	CENTER		WAYNE, IN46819	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0312 SS=D	of daily living receito maintain good in personal and oral Based on obse and interview, the provide document assessment and frequency of too 5 residents (Rethe criteria for the also failed to too (Resident #37 amet the criteria Stage 2 Sample Findings including the record individual of the recor	rvation, record review he facility failed to entation of a bladder d document the ileting needed for 1 of sident #37) who met oileting. The facility ilet 2 of 5 residents and Resident #23) who for toileting in the e of 36.	F0312	F 312 SS: D ADL care provi for dependent residentIt is th policy of Riverbend Health C Center to comply with regula requirement ADL care is provifor dependent resident.1. Resident #37 re-assessed for bladder incontinence and carplan revised as indicated. Re #23 re-assessed for bladder toileting plan and care plan a indicated.2. Facility reviewed residents to ensure bladder assessments completed. Fathas conducted a review of residents who are incontinent bladder and on toileting prog to ensure care plan is accurate and implemented appropriate per documentation.3. Licens staff re-educated on facility pand procedures related to: bladder incontinence and toil program. Nursing staff	e are tory vided r re es sd cility et of rams atte ely seed solicy

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL		
AND TEAN	or condition	155359		LDING		10/24/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF I	PROVIDER OR SUPPLIER	2			INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	*		DATE
		disease, depression,			re-educated on facility policy procedure related to bladder		
	· · · · · · · · · · · · · · · · · · ·	osteoarthritis. No			assessments.IDT will review		
	documentation				daily clinical meeting resider		
		as noted in the clinical			coded, as a change in contir	ence	
	record during r	ecora review.			re-assessed and care plan revised and implemented as		
	Resident #37 v	vas observed from 9:50			indicated. DON or designee		
		p.m. on 10/20/11. The			QA residents on toileting pro		
	resident was n	•			daily x 2 weeks then weekly		
		rief changed during this			then monthly to ensure resident toileting needs are maintained.		
	time period.	ner onanged danng tino			thr residents plan of care.DC		
	unio ponod.				designee will QA new admis		
	Resident #37 v	vas observed on			for bladder assessments and		
		8 a.m., being wheeled			toileting plans x 3 months for		
		m by CNA #4 after			accurate assessments.4. Re from QA reviews will be	Suits	
		0:27 a.m., CNA #4			forwarded to the facility Risk		
		nt to an activity. The			Management Quality		
		ot observed to be			Improvement (RMQI) commi	ttee	
		ncontinence brief			for further review and recommendations, until 100°)/	
		:33 p.m., the resident			compliance is achieved time		
	_	and the resident's			months.		
	•	rief was changed.					
		3					
	The current ca	re plan for alteration in					
		tion, dated 9/22/10,					
		e of 11/29/11, indicated					
	_	continent episodes and					
		ssary. There was no					
		w often to check the					
	resident for inc						
	The annual Mir	nimum Data Set (MDS)					
	Assessment, d	ated 9/2/11, indicated					
	Resident #37 v	vas frequently					
	incontinent of t	pladder and always					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED
NAME OF F	PROVIDER OR SUPPLIER	2		DDRESS, CITY, STATE, ZIP CODE	•	
RIVERBE	END HEALTH CAR	E CENTER		INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(computer progon 10/21/11, in was incontinent but did not indicheck the resident 4 on 10/21/11 the interview, Computer 137 serior 10/21/11 the interview, Computer 10	ent Care Tracker gram) for CNAs, printed dicated Resident #37 t of bowel and bladder cate how often to lent for incontinence. as conducted with CNA at 1:33 p.m. During CNA #4 indicated should be checked s for incontinence.				
	reviewed on 10 included, but we lumbar spine, of dementia, trause expressive approximately dioxide poisons ulcer, depressing disorder, and be hypertrophy. A Minimum Dadated 8/16/2014	or Resident #23 was 0/18/2011. Diagnoses were not limited to, berebellar ataxia, HTN, matic brain injury with masia, history of carbon mg, anxiety, peptic mg, psychosis, mood menign prostatic ta Set Assessment 1, indicated Resident ently incontinent of ired the extensive				

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359 A. BUILDING B. WING			(X3) DATE (COMPL 10/24/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		
RIVERB	END HEALTH CAR	E CENTER		INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	(X5) COMPLETION DATE
	A care plan for on-set date of 11/26/2 Resident #23 vurine. The goa "pericare to be assist after each thru (sic) next is Interventions/a care plan includimited to, "che episodes" and bathroom befor and prn (as new Con 10/18/2011 #23 was obsertion the Wester of the control of	vas incontinent of al was indicated as performed with staff ch incontinent episode review." pproaches listed on the ded, but were not ck for incontinent "assist to and from re and after each meal eded)." at 1:40 P.M. Resident ved sitting in his wheel est lounge. His gray ere observed to be wet				
	continuously of lounge from 9:1 P.M., dressed sitting in a whether Resident #23 with down at his laps sweat pants was that time, the redown the hall to	, Resident #23 was beerved in the West 30 A.M. until 12:00 in blue sweat pants, lel chair. At 12:00 P.M., was observed to look b. The groin area of his as noted to be wet. At lesident was observed lelf in his wheel chair to the nursing desk. He to sit there for five				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE COMPL		
		155359	B. WIN			10/24/2	011
NAME OF I	PROVIDER OR SUPPLIEF	- }			ADDRESS, CITY, STATE, ZIP CODE		
DI\/EDDI	END HEALTH CAR	E CENTED			INCHESTER RD VAYNE, IN46819		
					VATNE, IN40019		710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
,	minutes and th	en proceed to propel					
	himself to the o	dining room. No staff					
	were observed	to interact with the					
	resident or to c	heck him during the					
	observation pe	riod.					
	CNA #11 was i						
		11:00 A.M. During the CNA indicated that					
	-	vas incontinent of urine					
		sistance with toileting					
		e care. The CNA					
	further indicate	d residents were to be					
	either toileted	or checked for					
	incontinence e	very two hours and					
		er meals. The CNA					
		d Resident #23					
		hecked because he did					
	1	the staff when he					
	needed to be to	olleted.					
	On 10/20/2011	, Resident #23 was					
		oserved in the West					
	_	00 P.M. until 3:15 P.M.,					
	•	same seat pants,					
	sitting in his wh	neel chair. The groin of					
	the sweat pant	s were observed to be					
	wet. At 3:15 P	.M., CNA #10 was					
	-	opel Resident #23 to					
		resident's sweat pants					
		was observed to be					
		urine all the way down					
		A #10 was interviewed					
		uring the interview, the					
	CNA indicated	the day shift CNA had					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155359	A. BUILDING B. WING		10/24/2011
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE	
RIVERBE	END HEALTH CARE	CENTER		VAYNE, IN46819	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the resident sin The resident was attend bingo du The DON was in 10/21/11 at 2:1 interview the Dowere expected incontinence or hours depending resident. She for residents were and after meals A facility policy continence man	5 P.M. During the ON indicated staff to check residents for toilet them every 2 ag on the needs of the arther indicated to be toileted before s. on bowel and bladder nagement, with a f 8/2010, indicated are provided to			
F0323 SS=D	environment rema hazards as is poss receives adequate devices to prevent Based on obse and interview, t	nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents. rvation, record review he facility failed to care plan with the	F0323	F 323 SS: D Free of Accident and HazardsIt is the policy on Riverbend Health Care Cent comply with regulatory requirement free of accidents	f er to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION OO		(X3) DATE SURVEY COMPLETED		
		155359	A. BUI B. WIN	LDING IG		10/24/2	011
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER				INCHESTER RD		
RIVERBE	END HEALTH CARE	E CENTER			VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG			DATE
		of the dycem (non-slip			hazards.1. Res #37's Care I revised to include the intervention		
	1	wheelchair for 1 of 5			of dycum (non-slip material).		
	,	dent #37) who met the			The facility has conducted a		
		dents in the Stage 2			review of residents who have		
	Sample of 26.				fallen two or more times in th		
	l <u>_</u>				past 6 months from w/c to in care planned interventions a		
	Findings includ	e:			place and effective.3. Licens		
		0.00			staff will be re-educated on f	acility	
		3:02 p.m., Resident			policy and procedure related		
		ved in her room, no			fall risk and implementation		
	dycem was not	ed in the wheelchair.			care-planned interventions a place and effective. The facili	ty	
	On 10/24/11 at	9:10 a.m., Resident			interdisciplinary team (IDT) v review residents who have fa		
	#37 was observ	ved in bed. The			in daily clinical meeting to er		
	resident's whee	elchair was sitting			appropriate/effective interver		
	beside the bed	with a pressure			are implemented and care p	an	
	reducing cushic	on in the seat along			revised to reflect new interventions. Residents wh	•	
	with the hoyer s	sling pad. No dycem			have fallen referred to therap		
	was observed.				post fall. DON or designee w	-	
					conduct random visual		
	A review of the	clinical record for			observation of 2 residents da		
	Resident #37, o	on 10/17/11 at 2:30			two weeks then weekly x 1 n then monthly to assure	nontn	
	p.m., indicated	a telephone order,			interventions for fall risk are	in	
	1 ·	for dycem to be placed			place as care planned.4. Re		
	on Resident #3	7's wheelchair seat.			from QA reviews will be		
					forwarded to the Facility Risk	(
	A condition cha	ange form, dated			Management Quality Improvement (RMQI) commi	ttee	
		ted Resident #37 had			for further review and	ucc	
	an assisted fall	from her wheelchair in			reccommendations as indica	ted.	
	the dining room	n. The form indicated					
	Resident #37 s						
		t and was assisted to					
	the floor by stat	ff.					
	_						
	Nurse's Notes,	dated 1/15/11 at 11:30					

000250

A. BUILDING	OMPLETED 24/2011
STREET ADDRESS. CITY. STATE. ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 7519 WINCHESTER RD	
RIVERBEND HEALTH CARE CENTER FORT WAYNE, IN46819	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
a.m., indicated Resident #37 was	DATE
assisted to the floor after the resident	
slid from her wheelchair. The note	
further indicated the resident's hoyer	
pad was removed and dycem was	
placed in the chair.	
A facility care plan Potential for Falls,	
dated 3/24/11 with a goal date of	
11/29/11, did not include the	
intervention of dycem in the	
wheelchair.	
0)10 1/4 1/4 1/4 1/4 1/4 1/4 1/4 1/4 1/4 1/4	
CNA #4 was interviewed on 10/24/11 at 9:10 a.m. During the interview,	
CNA #4 indicated Resident #37 used	
to use dycem (non-slip material) but	
not anymore. She further indicated	
none was in the wheelchair currently,	
just a cushion.	
The company policy for Fall Biols	
The current policy for Fall Risk Reduction & Management, dated	
8/10, was provided by the Director of	
Nursing on 10/21/11 at 10:00 a.m.	
The policy listed the following: "The	
interdisciplinary team works with the	
resident/patient and/or	
family/responsible party to identify	
and implement appropriate	
interventions to reduce the risk of falls	
or injuries while maximizing dignity	
and independenceRevise the care plan to indicate changes in	
interventions as indicatedModify	

000250

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00	COMPLI	ETED
		155359	B. WIN	NG		10/24/20)11
	ROVIDER OR SUPPLIER			7519 WI	.DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
		goals and interventions communicate changes ng team"					
F0329 SS=D	from unnecessary drug is any drug w (including duplicate duration; or withou without adequate i the presence of ac indicate the dose s	ug regimen must be free drugs. An unnecessary then used in excessive dose e therapy); or for excessive at adequate monitoring; or ndications for its use; or in diverse consequences which should be reduced or my combinations of the					
	resident, the facility residents who have drugs are not given antipsychotic drug treat a specific condocumented in the residents who use gradual dose reduinterventions, unlein an effort to discourse desidents.	ehensive assessment of a y must ensure that e not used antipsychotic in these drugs unless therapy is necessary to indition as diagnosed and e clinical record; and antipsychotic drugs receive ctions, and behavioral ss clinically contraindicated, ontinue these drugs.	F(0329	F 329 SS: Drug Regimen is	free	11/23/2011
	the facility failed	d to ensure a gradual (GDR) was attempted	1	1349	from unnecessary drugs.It is policy of Riverbend Health Ca	the	11/ <i>43</i> /4011
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	UZK811	Facility I	D: 000250 If continuation sh	neet Pac	ge 73 of 91

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE COI LDING	NSTRUCTION 00	(X3) DATE : COMPL		
		155359	B. WIN			10/24/2	011
	PROVIDER OR SUPPLIER			7519 WI	DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	physician regar not attempting residents (Resi #10) reviewed medications. Findings includ 1. Resident #3 reviewed on 10 The record indi diagnoses including medications in the record individual of the resident was (antidepressant). A Pharmacy Contral (antidepressant) and contral (antidepressant) are resident was (antidepressant). A Pharmacy Contral (antidepressant) are resident was (antidepressant) are resident was (antidepressant) are resident was (antidepressant).	7's record was /17/11 at 2:30 p.m. cated Resident #37's ided, but were not estive heart failure, disease, depression, osteoarthritis. Order Plan of Care for dated 8/6/10, indicated is receiving celexa it) 20 mg every day. Onsultant Report, dated ated Resident #37 "has in (celexa) 20 mg QD management of major order since onsider documenting is reduction (GDR) is indicated" The ind the report December the recommendation			Center to comply with regula requirement drug regimen is from unnecessary drugs.1. F #37 re-assessed by physician a gradual dose reductuin has been acted on. Res #10 re-assessed by physician and documentation on GDR has completed.2. Facility has reviewed pharmacy GDR recommendation, past 60 da ensure physician has documented rational as to what reduction not attempted.3. Administrator to re-educate facility physician on regulation 329 and GDR documentation will review GDR in monthly concern review meeting to ensure documentation reflects ration to why reduction not attempted to why reduction not attempted for ecommendations for appropadocumentation by physician includes rational as to why reduction not attempted.4. Results from QA reviews will forwarded to the Facility Risk Management Quality Improvement (RMQI) comming for further review and reccommendations as indicated.	free Res n and s d been ys, to ny n n.IDT are all as ed or ed by ee DR riate be c ttee	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155359		(X2) MULTIPLE CC A. BUILDING	ONSTRUCTION 00	(X3) DATE COMP: - 10/24/2	LETED	
	PROVIDER OR SUPPLIER		7519 W	ADDRESS, CITY, STATE, ZIP CO INCHESTER RD WAYNE, IN46819		
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	ULD BE	(X5) COMPLETION
TAG	A Pharmacy Co 09/28/11, indicated Residual citalopram 20 m 8/09. The report 10/7/11 confirm appropriate. The Director of interviewed on During the interindicated the fapolicy and processory and processory are for signature or 2. Resident # reviewed on 10 The record indicated the fapolicy and processory and multiple so A Pharmacy Co 4/18/11, indicated the fapolicy and multiple so A Pharmacy Co 4/18/11, indicated to, depressive synconsider a grade There was no consider a grade There	Nursing (DON) was 10/24/11 at 8:15 a.m. rview, the DON acility does not have a redure for Pharmacy ports. She indicated given to the physician of follow-up. 10's record was 1/17/11 at 3:00 p.m. cated Resident #10's reded, but were not ression, fibromyalgia, lerosis. Onsultant Report, dated ted "has taken g every day since	TAG	CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	DATE

PRINTED: 11/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPLI			
		155359	A. BUIL B. WING			10/24/20		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		7519 WINCHESTER RD					
RIVERBE	END HEALTH CARE	ECENTER		FORT W	/AYNE, IN46819			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PR F F IX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE	
1710	GDR was not to	· · · · · · · · · · · · · · · · · · ·		1710	·		DATE	
	02111110110110110	o be attempted.						
	10/19/10, indicated cymbalta 60 mg 3/15/09 for mark depressive sympletric consider a grade. There was no dephysician on the	g every day since nagement of nptomsplease lual dose reduction" locumentation by the e form indicating why a						
GDR was not to be attempted.								
	3.1-48(a)							
F0333		nsure that residents are ant medication errors.						
SS=A	Based on record the facility failed resident received medication for (Resident #37) medications in a 36. Findings include	d review and interview, d to ensure each ed the correct 1 of 10 residents reviewed for a Stage 2 Sample of	F0	333	F 333 SS: A Resident Free fr significant med errorsIt is the policy of Riverbend Health Caracter to comply with regular requirement free from med errors.1. Res #37 unable to complete corrective action for resident at this time.2. DON designee QA orders against MARS/TARS to insure accurs of orders on. No other errors notified.3. Licensed nursing re-educated on the facility po	are tory r or acy	11/23/2011	
		-			and procedure related to			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UZK811

Facility ID:

000250

If continuation sheet

Page 76 of 91

NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER RIVERBEND HEALTH CARE CENTER (A4) ID PRETTY CACID PRICINSCY MIST RE PRACTICID BY TRILL TAG RESIDEATING DEPARTMENT OF DEPART	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
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#22 for January 2011, indicated the following afternoon medication [4:00 p.m.]: benztropine 2 mg, geodon 60 mg, senna laxative, topamax 25 mg, calcium 600 with vitamin D and advair			5					
#22 for January 2011, indicated the following afternoon medication [4:00 p.m.]: benztropine 2 mg, geodon 60 mg, senna laxative, topamax 25 mg, calcium 600 with vitamin D and advair		The Medication	n Record for Resident					
following afternoon medication [4:00 p.m.]: benztropine 2 mg, geodon 60 mg, senna laxative, topamax 25 mg, calcium 600 with vitamin D and advair								
p.m.]: benztropine 2 mg, geodon 60 mg, senna laxative, topamax 25 mg, calcium 600 with vitamin D and advair			-					
mg, senna laxative, topamax 25 mg, calcium 600 with vitamin D and advair			-					
calcium 600 with vitamin D and advair		· •	G : G					
		•						
50/100 one puff.								
		50/100 one pu	ff.					

PRINTED: 11/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155359		LDING	00	COMPL: 10/24/20	
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10/2 1/2	
NAME OF P	PROVIDER OR SUPPLIEF	R			INCHESTER RD		
RIVERBE	END HEALTH CAR	E CENTER			VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADED TO THE A			COMPLETION DATE
IAG		plan for Impaired		IAG			DATE
		sident #22, with a start					
	I -	0 and a goal date of					
		ated she had both					
		term memory deficits					
		cognitive impairment.					
		·					
		file was reviewed on					
		00 p.m. for the nurse					
		dication error [RN #12].					
		file indicated the nurse					
		nated due to poor job					
	•	The file also indicated					
		t notify the DON or					
		of a resident going to discontinuous discont					
	•	ations at the bedside of					
		had not checked to					
		resident took the					
		e date for the nurse					
	was listed as 1	/12/11 with her					
	receiving her F	RN status effective					
	9/19/85.						
		f Nursing (DON) was					
		10/25/11 at 11:15 a.m.					
		rview, she indicated					
	she could not f	on the incident report.					
		оп ше шошені тероп.					
	3.1-25(b)(9)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			(X2) MULT A. BUILDI B. WING		OO	(X3) DATE S COMPL 10/24/20	ETED
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE NCHESTER RD		
RIVERBE	END HEALTH CARE	CENTER			AYNE, IN46819		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		E	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	7	ΓAG	DEFICIENCY)		DATE
F0356 SS=D	on a daily basis: o Facility name. o The current date o The total number worked by the follor and unlicensed nuresponsible for research and to a licensed pra vocational nurses law). - Certified nurses law). - Certified nurses law). - Certified nurses law on Resident census The facility must prespecified above or beginning of each as follows: o Clear and readarch or line and visit The facility must, ure make nurse staffing public for review a community standarch and readarch and residents and visit of the facility must residents and visit of the facility must residents, or as required.	r and the actual hours owing categories of licensed rsing staff directly sident care per shift: urses. ctical nurses or licensed (as defined under State se aides. s. ost the nurse staffing data in a daily basis at the shift. Data must be posted ble format. lace readily accessible to ors. upon oral or written request, ig data available to the it a cost not to exceed the rd. naintain the posted daily in for a minimum of 18 uired by State law,					
	the facility failed nursing hours p date and was e residents and v observed. This	rvation and interview d to ensure the daily posted had the correct easily accessible for risitors on 1 of 6 days had the potential to residents and their	F035	56	F 356 SS: D Posted nurse staffing informationIt is the poof Riverbend Health Care Ce to comply with regulatory requirement posting nursing staffing information.1. Nurse staffing posted is now at w/c with correct date and information.2. No residents waffected by the practice.3. D	nter level vere	11/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155359	A. BUII B. WIN			10/24/20	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE NCHESTER RD		
RIVERBE	END HEALTH CARE	E CENTER			/AYNE, IN46819		
(X4) ID		FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)			(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)					COMPLETION DATE
	visitors. Finding Includes: During the initial tour on 10/17/11 at 10:30 a.m. observation of the daily nursing hours posted were dated 10/14/11. The posting was noted to be on the wall next to the beauty shop at eye level. On 10/18/11 the posting had the correct date. On 10/20/11 at 2:00 p.m. the administrator was informed of the posting having the wrong date on 10/17/11 and that it was not accessible to people in wheelchairs.				/ x 4		
					weeks. Then monthly x 2 months.4. Results from QA reviews will be forwarded to the Facility Risk Management Qualimprovement (RMQI) commit for further review and reccommendations, until 100 compliance is achieved times months.	uality tee %	
F0371	3.1-13(a) The facility must -						
SS=F	(1) Procure food fr considered satisfa local authorities; a	distribute and serve food					
	Based on obse	rvation, record review	F0	371	F 371 SS: F Food procurements store/prepare serve sanitaryl		11/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155359	B. WIN	IG		10/24/2	U11
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
TWINE OF I	NO VIDER OR BOTT EIER			7519 W	INCHESTER RD		
RIVERBI	END HEALTH CARI	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		the facility failed to			the policy of Riverbend Heal	th	
	ensure dishes	were washed using			Care Center to comply with		
	appropriate lev	els of sanitizer solution			regulatory requirement food procurement store, prepare	and	
	in the dish mad	chine and failed to			serve sanitary1. Upon notifi		
	submerge dish	es in the three			from the surveyor facility		
	compartment s	ink for the appropriate			contacted ECOLAB to service		
		or sanitization process.			dish washing machine. The		
		her failed to ensure			facility staff #2 stopped using machine and awaited ECOL	-	
	1	2 handled food with			service technician evaluation		
		sils and washed hands			machine. Ecolab service	. •.	
	_	s had the potential to			completed and facility order	new	
affect 45 of 46 residents who ate food				squeeze tubes and installed	on		
	prepared by the facility kitchen.				11/21/11 and issue was		
					resolved.Dietary manager completed re-education with		
	Findings includ	e·			dietary staff #2 on the prope		
	Timumigo miorad				procedure for 3-compartmer		
	1 On 10/17/1	1 at 9:40 a.m., dishes			sink once notified by surveyo	or.2.	
		being washed in the			ECOLAB completed dish		
		hine by Dietary #2.			machine service on 10/21/17	l to	
		Dietary Staff #2			ensure proper functioning.3. Dietary staff re-educated on	3	
	•	strips are used to check			compartment sink, dish mac		
		•			sanitation and chemicals.Die	etary	
		levels every morning			Manager or designee will QA	A dish	
		times during the day			machine daily x 7 days then		
		ntation log on the wall.			weekly x 4 then monthly to e dish machine chemicals are	insure	
		tion was noted for the			dispensing properly.Dietary		
		16/11 and for 10/17/11.			Manager will conduct QA ref	urn	
		per then proceeded to			demostration x 2 months of		
		ng solution in the dish			dietary staff to ensure they a		
		as unable to get the			following policy related to the		
	· ·	gister after four			compartment sink.Dietary st re-educated on the proper	all	
	attempts.				handling of raw food and ha	nd	
					washing procedure per Dieta		
		9:42 a.m., the three			manager.4. Results from Q		
		ink was observed with			reviews will be forwarded to		
	one sink filled v	with soap, one sink with			Facility Risk Management Q	uality	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X:	2) MULTIPLE CO			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A.	BUILDING	00		COMPL	
		155359	В.	WING			10/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STA			
חו/יבים		C CENTED			INCHESTER RI			
	END HEALTH CARI				WAYNE, IN4681 ·	ਤ 		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION DATE
IAU				IAU		t (RMQI) commit	tee	DATE
	•	d the third sink was			for further rev	` '		
	empty with no drain stopper in sight. Dietary Staff #2 was observed washing pots and pans without using the sanitizing rinse. When queried,				reccommend	lations, until 100)%	
						s achieved times	3	
					months.			
	_	per indicated the pans						
		were washed earlier.						
		eeded to search the						
	•	nk stopper. Once a						
		und, she then filled the						
		anitizer solution and the						
		ere within normal						
	limits. Dietary							
		vash additional pans						
	· ·	heet in the sink dipping						
		ne sanitizer briefly						
		onds) before putting the						
	items on the ra							
		ion for drying.						
	On 10/17/11 at	t 10:00 a.m., the						
		tion had drained from						
	_	partment sink. The						
	· ·	er went looking for						
	, ,	er for the sink before						
		initizing solution.						
		Ŭ						
	The Dietary Ma	anager was interviewed						
		10:07 a.m. During the						
		Dietary Manager						
	· ·	ishes should be						
	submerged in t	the sanitizing solution						
	_	seconds. He further						
	indicated he wa	asn't sure why the dish						
		itizing solution was not						
		dicated the container						
FORM CMS-2	567(02-99) Previous Version		UZK	311 Facility	ID: 000250	If continuation sh	neet Par	ge 82 of 91

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO.	NSTRUCTION	COMPL	
AND PLAN	OF CORRECTION	155359	A. BUI	LDING	00	10/24/2	
		155559	B. WIN			10/24/2	011
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
DI) /EDD	TAID LIE AL TIL CADI	- OFNITED	7519 WINCHESTER RD				
RIVERBE	END HEALTH CAR	= CENTER		FORTV	VAYNE, IN46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of solution was	half full but was not					
	getting into the	dish machine.					
	Cleaning & Sar was provided bon 10/24/11 at indicated "Te chemical streng each meal and Machine/Sanitiz compartment s and utensils in in clear water for at least one The Dietary Ma of the sanitizing instructions on The undated producement indicated producem	licy and procedure for nitizing, dated 6/09, by the Dietary Manager 8:15 a.m. The policy imperatures and geth will be checked at recorded on the Diship zer Logfill three (3) inkwash pots, pans, hot soapy waterrinse put in sanitizing sink (1) minute" Inager provided a copy gesolution manufacture 10/24/11 at 8:43 a.m. roduct specification for less than 1 minute" If at 10:00 a.m., Dietary pserved removing the sh can and throw by before replacing the can. After this, the roceeded to obtain a					
		er and make a pot of					
	conee without \	washing hands first.					
	On 10/17/11 at	10:02 a.m., Dietary					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 10/24/2	ETED	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN46819		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	COMPLETION DATE
1710		oserved chopping up		mo			DATE
		sing his bare hands to					
	hold the banana on the cutting board.						
		nas were cut into					
		aff member picked up					
		ces with bare hands					
	and placed in a	a Container.					
	On 10/17/11 at	t 10:12 a.m., Dietary					
		d hands and turned off					
		bare hands before					
		vith a paper towel. The					
		hem proceeded to get					
		ocktail, open it without I, and proceeded to					
	_	ocktail in with the					
	· ·	ad been cut up a few					
		. Next the Dietary Staff					
		lid with bare hands to					
		can. The staff					
		ot wash hands before					
	the fruit cockta	gather a spoon and stir					
	are man cockta						
	On 10/24/11 at	8:15 a.m., the Dietary					
	Manager provi	ded the current policy					
	•	for Handwashing,					
		ne policy included, but					
	was not limited washed after c	to: hands must be					
		tems or surfaces, turn					
		hands thoroughly,					
	· ·	ry hands with paper					
		cets off with the paper					

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED
NAME OF	PROVIDER OR SUPPLIER		J	STREET A	DDRESS, CITY, STATE, ZIP CODE NCHESTER RD		
RIVERB	END HEALTH CAR	CENTER			/AYNE, IN46819		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	ŀ	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	towel.	<u> </u>					
	3.1-21(i)(2)						
F0428 SS=D		of each resident must be once a month by a licensed					
	to the attending ph	ust report any irregularities nysician, and the director of e reports must be acted					
	the facility failed Consultant Rep by the physicia	rd review and interview, and to ensure Pharmacy borts were acted upon an for 2 of 10 residents and Resident #10 addications.	F04	128	F 428 SS:D Drug Regimen review It is the policy of Riverbend Health Care Centrocomply with regulatory requirement Drug regimen review, report, irregular, act of Res #37 re-assessed by physicianand a gradual dose	on.1.	11/23/2011
	Findings includ	e:			reduction has been acted on # 10 re-assessed by physicia and documentation on GDR	ın	
	The record indi diagnoses including limited to, cong coronary artery dementia, and An Admission (Resident #37, of the resident was	/17/11 at 2:30 p.m. cated Resident #37's ided, but were not estive heart failure, disease, depression,			been completed2. Facility has reviewed pharmacy GDR recommendation, past 60 da ensure physician has documented rational as to what reduction not attempted.3. Administrator to re-educate facility physician on regulation 329 and GDR documentation will review GDR in monthly controlled to the review meeting to ensure documentation reflects ration to why reduction not attempted recommendation not accepted.	ys, to ny n.IDT are aal as ed or	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/24/2	ETED
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER			7519 W	DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	11/11/10, indicataken citaloprar (every day) for depressive disc 8/09please or that gradual do clinically contrar physician signer 2010 declining for GDR but did rationale. A Pharmacy Co 09/28/11, indicated recommendation GDR of citalops indicated Residual citalopram 20 m 8/09. The report 10/7/11 confirm appropriate. The Director of interviewed on During the interviewed on During the interviewed on Consultant Reports are for signature or	consider documenting se reduction (GDR) is sindicated" The sed the report December the recommendation of not document. Consultant Report, dated ated "Repeated on from 6/20/11" for ram. The report lent #37 was receiving ang every day since out was not signed until aning a GDR is Nursing (DON) was 10/24/11 at 8:15 a.m. review, the DON acility does not have a redure for Pharmacy ports. She indicated given to the physician		MD.Social Service or design will QA monthly pharmacy of recommendations for approdocumentation by physiciar includes rational as to why reduction not attempted.4. Results from QA reviews with forwarded to the Facility Ris Management Quality Improvement (RMQI) common for further review and reccommendations as indicated in the province of the provinc	GDR priate II be k ittee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				NSTRUCTION 00		X3) DATE COMPL	
		155359		A. BUILI				10/24/2	
		.50000		B. WING		DDDEGG GITM GT TT T	ID CODE	10,21,2	· · ·
NAME OF P	ROVIDER OR SUPPLIER					DDRESS, CITY, STATE, Z	IP CODE		
DIVEDDE	END HEALTH CARI	E CENTED				INCHESTER RD VAYNE, IN46819			
	IND HEALTH CAR	CENTER			FORT W	VATINE, IN40019			
(X4) ID		TATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF			(X5)
PREFIX	*	CY MUST BE PERCEDED BY F		P	PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		HE APPROPRIAT	PRIATE	
TAG		LSC IDENTIFYING INFORMA	TION)		TAG	DEFICIENCY	r)		DATE
)/17/11 at 3:00 p.m.							
		cated Resident #10'	S						
	_	uded, but were not							
	limited to, depr	ession, fibromyalgia,	,						
	and multiple sc	lerosis.							
	A Pharmacy Co	onsultant Report, da	ted						
	4/18/11, indicat								
		g every day since							
	3/15/09 for mai	• •							
		nptomsplease							
		dual dose reduction	"						
	_	documentation by the							
		e form indicating wh							
		o be attempted.	yu						
	ODIT Was not to	o be attempted.							
	A Pharmacy Co	onsultant Report, da	ted						
	_	ated "has taken							
	=	g every day since							
	3/15/09 for mar								
		nptomsplease							
	•	dual dose reduction	"						
	_								
		documentation by the							
	· ·	e form indicating wh	y a						
	GUK was not to	o be attempted.							
	0.4.05()								
	3.1-25(h)								
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Eve	nt ID: UZ	K811	Facility II	D: 000250 If	continuation sh	eet Pa	ge 87 of 91

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 10/24/2	ETED
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER				7519 W	DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0514 SS=D	each resident in a professional stand complete; accurat accessible; and sy. The clinical record information to ider the resident's assaud services provipreadmission screstate; and progress Based on obseand interview, the use of a harmous (Resident #5) adocumentation wheelchair for 37) of 36 resides 2. Findings includes 1. Review of the resident #5 on indicated #5 on indicated #5 on indicated the resident #5 on indicated the resident #5 on indicated #5 on indicated the resident #5 on indicated the resident #5 on indicated the resident #5 on indicated #5 on indicated #5 on indicated the resident #5 on indicated #	rvation, record review the facility failed to e documentation for and splint for 1 resident and accurate for dycem in a 1 resident (Resident # ents reviewed in Stage) e: ne clinical record for 10/19/11 at 9:30 a.m. esident was admitted to /28/11 with diagnoses of limited to Hemiplegia tes, Neuropathy and	F0:	514	F 514 SS: D Records- complete/accurate/accessible the policy of Riverbend Healt Care Center to comply with regulatory requirement reside records complete, accurate a accessible.1. Res #37's Car Plan revised to include the intervention of dycum (non-si material). Res #5 is currently therapy caseload for evaluati and treatment for splint application per MD order.2. facility has reviewed documentationlast 30 days for inaccuracy and omissions.3. Licensed staff re-educated or facility policy and procedure related to complete and accur documentation.DON or desig will QA in daily clinical meetin documentation of licensed st for completeness and accura Corrective education will be completed as indicated.4. Results from QA reviews will forwarded to the Facility Risk Management Quality	h ent ind e lip / on on The or n trate inee ing aff icy.	11/23/2011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE (A. BUILDING B. WING	00	, ,	E SURVEY PLETED 2011
NAME OF PROVIDER OR SUPPLIE		7519	r address, city, state, zip codi WINCHESTER RD WAYNE, IN46819	-	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE OPRIATE	(X5) COMPLETION DATE
10/17/11 at 11 resident was inher left arm wittowards her left hand was noted interview with 10/17/11 at 11 had lived at a a hand splint is coming to the On 10/18/11 at the resident's 6/28/11 indicated wear a left hand up to 6 hours therapy carrott tolerated. Als before and afted hand/arm was before and afted interview with at 11:00 a.m. know the resident on 10 resident was contained indicated indicated indicated indicated indicated indicated indicated indicated indicated in the resident in the resi	at 9:30 a.m. review of admission orders dated ted the resident was to and splint during the day and replace with a throughout the night as an order to check skin er splint applied to left h and dry areas well er splint application. Inurse # 6 on 10/18/11 andicated she did not lent was to have a ant. Observation of the lent was to have a ant. Interview with the lated staff had found the		Improvement (RMQI) co for further review and reccommendations, until compliance is achieved months.	100%	

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155359	B. WIN	G		10/24/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					INCHESTER RD		
RIVERBEND HEALTH CARE CENTER				FORT V	VAYNE, IN46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with CNA # 4 a	nd #7 indicated they					
	had never seer	n the resident wear a					
	hand brace.						
	On 1020/11 at	2:30 p.m. review of the					
	October 2011 "	Treat Administration					
	Record" for the	resident indicated					
	nursing staff we	ere signing every shift					
	_	nt was wearing a hand					
		skin was being checked					
		er the application of the					
	splint.	a the approach of the					
	Орини.						
	2 On 10/20/11	at 3:02 p.m., Resident					
		ved in her room, no					
		ed in the wheelchair.					
	l dycelli was not	ed in the wheelchair.					
	On 10/24/11 at	9:10 a.m., Resident					
		ved in bed. The					
		elchair was sitting					
		with a pressure					
		on in the seat along					
		sling pad. No dycem					
	was observed.						
		der, dated 1/15/11,					
	1	n was to be placed on					
	Resident #37's	wheelchair seat.					
		dated 1/15/11 at 11:30					
	a.m., indicated	Resident #37 was					
	assisted to the	floor after the resident					
	slid from her w	heelchair. The note					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/24/2011	
	PROVIDER OR SUPPLIER		7519 W	ADDRESS, CITY, STATE, ZIP CODE /INCHESTER RD //AYNE, IN46819	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		d the resident's hoyer yed and dycem was hair.			
	CNA #4 was in at 9:10 a.m. D CNA #4 indicate to use dycem (not anymore. none was in the just a cushion. The October 2 for Resident #3 [wheelchair] see every shift. The	terviewed on 10/24/11 uring the interview, ted Resident #37 used non-slip material) but She further indicated e wheelchair currently, 011 Medication Record 87 listed "dycem to w/c eat - check placement e sheet was signed by e dycem was checked			